The Utah Network on Juveniles Offending Sexually

Protocols and Standards Manual

Fifth Edition

PROTOCOLS AND STANDARDS
FOR YOUTH WHO ENGAGE IN SEXUAL MISCONDUCT

ADOLESCENT TREATMENT / PLACEMENT PROTOCOL

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AUTHOR'S NOTE

In NOJOS' early years, the community's response to the sexually abusive behaviors of youth was often to deny or minimize the seriousness of such behavior and the harm caused by such behaviors. Thus, efforts to raise public awareness were increased both locally and nationally. However, as a result of increased public awareness and misdirected comparisons of sexually abusive youth to adult sexual offenders, the potential to cause these youth harm has increased.

Juvenile justice response to delinquents was intended to recognize the misbehavior of youth as indicative of a need for corrective care and guidance, capitalizing on the resilient capacity of youth for rehabilitation. As early as the 1993 report from the National Task Force of the National Adolescent Perpetrator Network (NAPN), leaders in this field have advocated caution, to "do no harm," and to prevent extreme responses which might actually exacerbate rather than mitigate the risk of youth continuing to engage in sexually abusive behaviors. Nonetheless, recent years have seen the pendulum swing wildly to extremes which appear to defy common sense, juvenile recidivism findings, and the fundamental rehabilitative goals underlying juvenile sex-specific treatment and the establishment of the juvenile court system. Registration and public notification are only the most obvious signs of stigma for these youth. Experts and leaders representing research and practice in this field, and in other realms of child protection, child welfare, and human development, have voiced concerns in reports and testimony, advocating public health and evidence-based approaches. Practitioners and child advocates have shouted to be heard, while communities remain steadfast behind policies and legislation, which are no longer in the best interest of either the youth we serve or the future safety of our communities. While we remain committed to stopping the continuation of sexually abusive behaviors by the youth we treat, we must now also seek to protect their futures (Ryan, NAPN Conference Brochure, 2007).

In response to recent research and national concerns regarding the potential to stigmatize these youth and disrupt, rather than facilitate, their return to a normative path of development, the Editors of this fifth edition of the NOJOS Juvenile Sex Offender-Specific Protocols and Standards Manual have renamed the manual. The new name, "NOJOS PROTOCOLS AND STANDARDS FOR YOUTH WHO ENGAGE IN SEXUAL MISCONDUCT," hopefully conveys our belief and juvenile recidivism evidence that the majority of these youth will <u>not</u> go on to reoffend and our professional experience that they can, through caring specialized treatment, return to a more healthy, normative path of development. Additionally, because current national literature also calls for juvenile intervention models to pair risk reduction with increased health and competency development, we have also incorporated sex-specific treatment techniques into a more holistic, humanistic and developmentally consistent model for working with these youth.

It is our belief that these changes will once again integrate national best practice standards into the NOJOS continuum such that we can continue to provide state-of-the art intervention to address the needs of youth who engage in sexual misconduct. It is our privilege to work with these youth and be a part of their courageous journey to face the painful reality of their misconduct and develop new competencies and skills to help them become more loving and successful in their relationship with others as well as themselves.

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Best Practice Standard in Treating Youth Who Engage in Sexual Misconduct

The definition of best practice in treating sexually abusive youth is still in question (Chaffin & Bonner, 1998; Developmental Services Group, 2000, Hunter & Longo, 2004). While the field is not new, conceptualization of what constitutes effective treatment for this population is still evolving (Chaffin, Chapter 28; Hunter and Longo, 2004). However, over the last few years, research and juvenile sex-specific treatment techniques have changed substantially, highlighting the past misapplication of adult sex offender treatment models and the importance of modifying juvenile sex-specific treatment practices.

"As late as 2002, the majority of juvenile treatment programs have continued to adhere to a traditional adult sex offender treatment model" (Burton and Smith-Darden, 2007). National experts indicate adult approaches are misdirected with adolescents. "We can no longer allow adult programming to be the sole source of assessing and treatment young people" (Prescott and Longo, Current Perspectives: Working with Sexually Aggressive Youth & Youth With Sexual Behavior Problems, Longo, Robert E and Prescott, David S., Editors, NEARI Press, 2006). It is vital that mental health professionals are willing to explore and accept that many of the practices of the past may not be the most effective way of treating these youth.

All too often, clinical approaches have overlooked developmental and contextual issues. Many programs have focused treatment on areas that may not be relevant for the juvenile sex offender population, such as deviant sexual arousal (Freeman-Longo, 2002; Hunter, 1999; Hunter & Becker, 1994). Techniques and modalities used in treating adult sexual offenders have been directly applied to youth, or modified only slightly to make materials more easily understood, without taking into consideration learning styles, developmental issues, and intelligence variations of these clients (Gardner, 1983). However, youth are, by definition, different. They exist in a different context and at different developmental stages than adults. They often have unresolved histories of trauma, both physical and physiological. High levels of confrontation are still used in many programs. When used with traumatized youth, these techniques may serve to re-traumatize them instead of promoting healing, forgiveness, and respect for self and others. Even the recent research with adult sex offenders demonstrates that warm, empathic, rewarding, and directive therapeutic styles can produce better treatment outcomes than harsh and confrontational methods (Marshall, Fernandez, Serran, Mulloy, Thornton, Mann & Anderson, 2003). The best practitioners are warm and empathic, addressing all aspects of the youth's functioning, while maintaining a focus on those areas demonstrated to be associated with risk. Interventions that do not take the youth's family circumstances into consideration may well do harm in the long run.

Based on current research and professional opinion, "best treatment practices" with youth must be focused on developing an approach that meets the individual and developmental needs of youth and is reflective of the youth's individualized pathway to offending. Specifically, the sex-specific treatment approach must be sensitive to the youth's developmental trajectory and how experience, development, environment, society, and culture impact this trajectory and create dynamics, issues, and problems that placed the youth on a pathway to sexually offend.

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"We do not know exactly what variables need to be present, in what combinations, in what relationships to each other, at what critical points of development, with what intensities, and in what context, in order for sexual abuse to occur and be maintained" (Thomas 2006). However, what is clear is that sexual acting out is a result of multiple, interacting factors (etiological and maintenance factors) that converge at a particular point in time in a given context. These factors "have a cumulative effect" on the youth (Prescott 2006) diverting their normative path of development. It is about the convergence and melding of these factors that creates a synergistic reaction (Ward, Polaschek, and Beech, 2006). Etiological and maintenance factors include: disruption and deficits in development, inconsistent and unhealthy environments, deficits in executive functioning and problems with self regulation, cognitive distortions and underdeveloped values and morality, problems in emotional identification, expression and regulation, problems and deficits in self concept, self esteem and self identity, social competency and social relatedness problems, childhood trauma and maltreatment, awareness deficits and other co-morbid mental health issues and learning disabilities.

Sex-specific assessment should help identify which factors, in what proportion, and at what point in development youth were directed onto the pathway to offending. Additionally, treatment should assist the youth to increase competency and skills necessary to ensure their ability to control or eliminate the etiological and maintenance factors that influenced their pathway to offend, to reestablish a healthy developmental trajectory (in all developmental stages), to obtain their needs and human goods in a healthy way and to place themselves back on a healthy pathway towards becoming a functional, healthy and happy adult (Ward, T., Polaschek, D. and Beech, A. Theories of Sexual Offending, John Wiley & Sons, Ltd. 2006).

National literature endorses the use of a holistic, integrated approach to treating youthful sexual abusers (Longo, 2001; Hunter & Longo, 2004). This approach blends traditional aspects of sexual-abuser treatment into a holistic, humanistic and developmentally-consistent model for working with youth (Morrison, Chapter 13). While cognitive-behavioral treatment methods appear promising, treatment must go beyond the sexual problems and address "growth and development, social ecology, increasing health, social skills, resiliency, and incorporate treatment for the offender's own victimization and co-occurring disorders" (Developmental Services Group, 2000). If successful risk reduction involves changing thoughts and behaviors, then a holistic, integrated model prepares the youth to make these changes while respecting his/her long-term development (Prescott, David S., and Longo, Robert E., *Current Perspectives: Working with Young People Who Sexually Abuse*, Current Perspectives: Working with Sexually Aggressive Youth & Youth With Sexual Behavior Problems, Longo, Robert E and Prescott, David S., Editors, NEARI Press, 2006, page 54-56).

Holistic Developmental Approach

The primary aim in juvenile sex-specific treatment is to instill in the youth the knowledge, skills and competencies necessary to develop and implement a positive identity revolving around personally meaningful ways of meeting their human needs and pursuing their interests.
Thus, treatment is less focused on "deviant sexual arousal" and/or "sexual assault cycle" and more focused on factors related to the youth's developmental trajectory—the causal and maintenance factors that diverted the youth to a pathway to offend.

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Treatment interventions need to help the youth to successfully re-enter a healthy developmental trajectory and build the competency, resiliency, and protective factors necessary to resolve and/or eliminate etiological and maintenance factors that led them to offend.

According to the "Good Lives Model," treatment should help the youth acquire (in a healthy way) the skills and primary human goods (healthy living, knowledge, excellence in play and work, excellence in self agency, freedom from emotional turmoil and stress, friendship, community, purpose in life, happiness and creativity) required to be happy and healthy and live a good life (Ward, T.; Polaschek, D. and Beech, A. Theories of Sexual Offending, John Wiley & Sons, Ltd. 2006, page 297-313).

Nevertheless, as part of a holistic approach, treatment should integrate standard sex-offense-specific treatment components, such as development of full accountability for all offense behaviors, insight into offense dynamics and choice to offend, building realistic and effective self-regulation (relapse-prevention) strategies and skills, develop a family safety plan, develop healthy sexual attitudes, boundaries, sexual identity, and develop and sustain victim empathy and general empathy. Treatment should also include sex education and healthy sexuality interventions. A psychosexual education emphasis is needed to provide the youth with information regarding maturation, human development, healthy sexual functioning, the current laws regarding sexual conduct and a healthy sexual identity. Many of these youth also need opportunities to resolve their own childhood victimization with *sensory interventions* separate from focus on their sexual misconduct to assist them to resolve trauma, enhance emotional coping skills and develop a healthy sexual identity. Overall, treatment is about aiding these youth to understand themselves, their sexuality and sexual development, as well as own responsibility for their sexuality (thoughts, feelings, and behavior), further identifying that there are consequences for their choices, and develop competencies and skills to enter or reenter a normative developmental pathway for their sexuality and life.

NOJOS Certification and Training

Sex-specific treatment is a structured, multi-modal, multi-systemic, skill-based treatment. This treatment works best when it is relationship-based and is provided in a developmentally-sensitive, empathetic, warm, rewarding and directive environment. NOJOS also recognizes that these youth (when removed from their home and community) can be successfully reunified with their families/victims. However, to accomplish this, providers must assist youth in learning to generalize the skills they have developed into their family system as well as the community. This is accomplished through well-designed aftercare programs. NOJOS also understands that youth get healthier more quickly, and positive treatment progress occurs, with the inclusion of the youth's family in all aspects of assessment and treatment. Best practice sex-specific treatment is holistic, and it recognizes work with youth who engage in sexual misconduct is even more complex than traditional therapeutic approaches, as it deals with developmental and cognitive issues, personality development, family and community systems, a complex interplay between developing emotions and behaviors, the line between normative sex play and experimentation and the development of sexually abusive behaviors, psychiatric co-morbidity, social learning, and often the echoes of personal trauma in the youth (Rich, Phil. (2003);

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Understanding, Assessing, And Rehabilitating Juvenile sexual offenders; John Wiley & Sons, Inc., Page 4).

Clearly, the treatment of adolescent sexual issues is specialized and differs from generic mental-health treatment approaches. Indeed, "treatment requires a specially skilled clinician and clinical approach;" thus a "high level of therapist skill for clinicians working with youthful offenders is paramount" (Ward, T.; Polaschek, D. and Beech, A. Theories of Sexual Offending, John Wiley & Sons, Ltd. 2006, page 324). Accordingly, sex-specific treatment should be provided by NOJOS Certified Clinicians who have additional training and experience in working with juveniles, sexual abuse and sexual issues.

NOJOS Clinical Certification Requirements

1. Applicant must have a master's or doctoral degree in social work, psychology, marriage and family therapy, counseling, educational psychology, or mental-health field from a fully-accredited college or university, or a psychiatric nurse or a medical doctor if the individual is a board certified/eligible psychiatrist.

2. Clinical Status Applicants must have a current license from the Division of Professional and Occupational Licensing. Licensure should be in the mental-health field (i.e. psychiatry, psychology, licensed professional counselor, social work, or marriage and family therapy).

3. Within the three-year period immediately preceding this application, the applicant must have at least 2000 hours of direct, clinical contact in a sex-offender treatment program. Direct clinical contact is defined as a licensed/supervised mental health professional providing sex-specific therapeutic intervention to persons who have sexually offended, been offended on, and/or those whose lives have been impacted by sexual offending. Indirect clinical contact is defined as any activities, tasks, information gathering or related endeavors that will assist the provider. For example, case supervision, case staffing, file maintenance, session notes, attending or providing training, case coordination, publishing, and research). Included in the 2000 hours, there must be at least 1500 hours of direct clinical client contact, such as, individual, couples, group and/or family therapies.

4. Within the three-year period immediately preceding this application, the applicant must have completed a minimum of forty hours of formal sex offender-specific training through documented conferences, symposia, seminars or course work directly related to the evaluation and treatment of sex offenders. (The NOJOS Training Academies, NAPN, ATSA conference trainings meet the majority of the requirements.)

5. Clinical Status Applicants must have as a basic philosophy that comports with guidelines established by the National Adolescent Perpetration Network, the Association for the Treatment of Sex Abusers, and the Utah State Juvenile Sex Offenders Protocols and Standards Manual.

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6. Clinical Status Applicants must adhere to the child abuse reporting laws as required by the Utah State Department of Human Services and the State of Utah.

7. Clinical Status Applicants may supervise a maximum of three Affiliate Status providers.

8. All service providers who change from one program to another must update their application within sixty days of the change in order to maintain the credential status.

9. Criminal convictions or licensure actions prior to this application must be disclosed and may result in the application be denied. Failure to disclose any current or future criminal convictions or licensure actions may result in termination of any approved status (See www.nojos.org).

Treatment / Placement Philosophy

Placement decisions are the most important decisions in balancing the juvenile's risk to reoffend (community protection/abuse prevention) and the need to help the juvenile develop in a manner that increases the likelihood of a positive adult lifestyle (rehabilitation). Youth should be placed in the *least-restrictive environment* necessary to reduce/minimize risk and provide adequate treatment to facilitate positive growth. Risk-management practices must match the risk level of the juvenile offender. According to national standards, treatment is most effective when the intensity of services match the youth's risk of recidivism. Providing an inappropriate level of service may negatively affect a youth's risk, rehabilitation and community protection. Thus, accurate risk assessment is a prerequisite to determine appropriate parameters needed for risk management and rehabilitation (See Sex-Specific Assessment Protocols immediately preceding this section).

Community protection and rehabilitation is achieved through a continuum of eight levels of sex-specific treatment and supervision from least restrictive in-home intervention to secure care confinement. The continuum of services should allow movement up or down the continuum based on progress or regression in treatment. All agencies within the NOJOS continuum should have a common treatment philosophy and sex-specific best practices, which facilitates a continuity of care and seamless transition(s) as the juvenile moves up or down the continuum. Clinicians, probation officers and case managers should always recommend the optimal level of care needed, even if it is not available, for a specific client and then offer realistic alternatives documenting when the alternatives are less adequate.

It is imperative mental-health and juvenile-justice professionals work in a closely-coordinated manner to effectuate a comprehensive and individualized case-management plan. The integrated plan of services should be aimed at both maximizing community safety and ensuring that the youth and his/her family/care takers are given the intervention services they need. Additionally, and perhaps most importantly, sex-specific treatment along the continuum should be based on a *holistic approach* that addresses an integration of the entire functioning, context/family system and long-term development of each youth.

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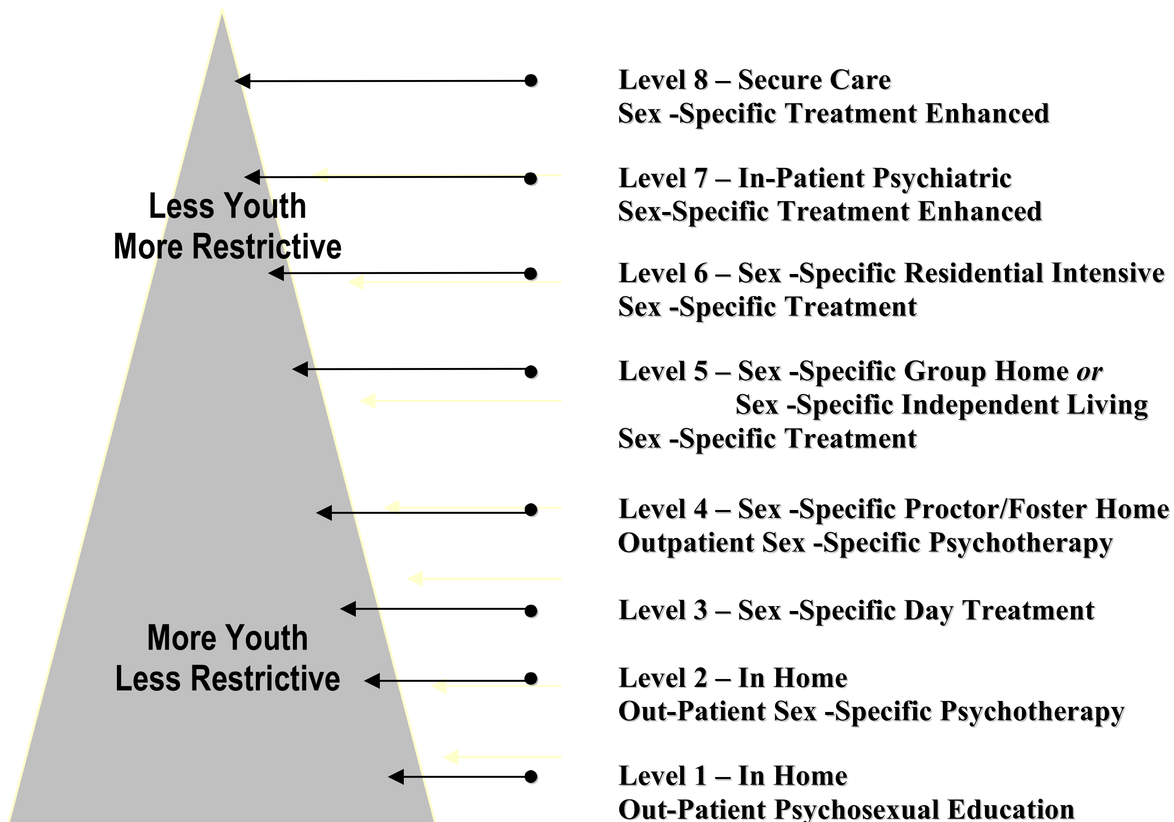
The NOJOS Continuum

Sexually abusive youth are best rehabilitated with a continuum of care and services (Bengis 1986, 2002a). The NOJOS Continuum consists of the following eight levels, beginning with the least restrictive "Level One" to most restrictive "Level Eight" as follows:



National Standards (Bengis, 2002) indicate "that use of a continuum requires special attention to the following criteria as a guideline for placement of clients:

1. The placement should correspond to the level of risk posed by the patient.
2. The level of client risk should be determined by examining both:
    a. the client's level of self-control (the bottom-line acting-out which the placement has been designed to contain), and
    b. the staff-client ratios present on-line to contain these behaviors.
3. Whenever legally possible, movement along the continuum should be based on the competency level achieved by the patient.
4. Required competency levels should correspond to the level of internal-control required for safe placement at each level of the continuum.
5. Initially, clients can be referred to any level of the continuum that corresponds to their diagnosed level of risk. However, decisions regarding movement to less restrictive placements should be competency-based.

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6. The entire continuum of care should use the same sex abuser-specific assessment and treatment criteria. While specific placements may emphasize different aspects of sex abuser-specific treatment, all placements should adhere to the guidelines established by the National Task Force on Juvenile Sexual Offending (1993). Sex abuser-specific treatment that takes place in other than outpatient settings, i.e., residential or day programs, should incorporate sexual abuser-specific milieu treatment. As such all staff in those placements should be trained:
   a. to provide abuser-specific interventions as part of their work on-line with youth;
   b. to integrate the basics of abuser specific treatment into interventions that do not involve sexually abusive behaviors; and
   c. to integrate abuser-specific issues into vocational and educational curricula.
   d. Programs (non-outpatient settings, i.e., residential or day programs) offering specialized assessment and specialized groups, but do not provide specialized milieu treatment, should not be considered sex abuser-specific programs.
7. Whenever possible, caregivers should remain consistent as a youth moves from one level of the continuum to another (i.e., probation officer, case worker, therapists).
8. Placements along the continuum should be evaluated:
   a. by professionals trained in both evaluation methodology and abuser specific assessment and treatment; and
   b. according to sex abuser specific criteria agreed to in advance by evaluators and those being evaluated.
9. The continuum should include long-term self-help and require community relapse prevention components.
10. Day programs and educational placements should be thoroughly integrated into the continuum of care and be required to provide sex abuser specific treatment.
11. All youth placed in programs anywhere along the continuum should receive pre and post abuser specific evaluations. These evaluations should be the basis for initial placement and for discharge to less restrictive settings. These evaluations should also screen the patient according to more traditional clinical criteria (i.e., thought disorders, clinical depression, ADHD, and other neurological criteria). (See Assessment Protocols and Standards section above.)

(Prescott, David S., and Longo, Robert E., *Current Perspectives: Working with Young People Who Sexually Abuse*, Current Perspectives: Working with Sexually Aggressive Youth & Youth With Sexual Behavior Problems, Longo, Robert E and Prescott, David S., Editors, NEARI Press, 2006, page 53-54.)

Another professional author outlines guidelines for when it is appropriate to remove a youth from his/her home and when it should not be considered:

In Home Placement should be considered when:

- It is in everyone's best interests;
- The juvenile is a relatively low risk offender;

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- The juvenile is likely to comply with supervision;
- Treatment services are in place;
- Risk-management strategies are in place; and/or
- It is not considered detrimental to the victim

In Home Placement <u>*should not*</u> *be considered when:*
- A history of severe abuse in the home by offender or others;
- The family is unwilling or unable to monitor risk;
- A history of repetitive assaults in the home despite prior interventions; and/or
- A high risk of reoffending and access to potential victims in the home or neighborhood

In Home Placement <u>*should not*</u> *be considered when:*
- Signs of sexual deviance and access to victim or victim-type in the home;
- It would be detrimental to the victim in the home;
- Substance abuse by offender or others; and/or
- Other factors that clearly indicate that risk cannot be managed in the home environment

(Coffey, Patricia, Ph.D., *Forensic Issues In Evaluating Juvenile Sex Offenders*, <u>Risk Assessment of Youth Who Have Sexually Abused</u>, Prescott, David S., LICSW, Wood & Barnes Publishing, 2006, page 80-81).

Sex-Specific Treatment Goals:

In 1993, the National Task Force on Juveniles Offending Sexually outlined treatment goals for juvenile sex-specific treatment. However, over time and with new information and research many of these goals needed to be reviewed. In 2003, Phil Rich a national renowned author in the field, revisited and revised the National Task Force treatment goals and objectives. Providers offering treatment to youth with sexual behavioral problems should ensure treatment addresses these goals. The following is a list of seventeen specific treatment areas identified as important in sex-specific treatment and rehabilitation:

1. Personal responsibility for behaviors;
2. Behavioral self-control, including interruption of patterns of dysfunctional behavior;
3. Pro-social behavior with the concomitant reduction of antisocial behavior;
4. Rational thinking and healthy attitudes, recognizing and eliminating cognitive distortions and attitudinal mind-sets that support sexually abusive behavior;
5. Healthy and appropriate self-expression;
6. Healthy and appropriate relationships with both peers and adults;
7. Improved self esteem and sense of personal identity;
8. Improved mental health with resolution of co morbid psychiatric conditions;
9. Addiction-free lifestyle with regard to both addictive and compulsive sexual behaviors and substance use;
10. Intellectual improvement and development, recognizing and addressing cognitive impairments and developmental delays where present;

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11. Healthy sexual attitudes, fantasies, and identity and the reduction or elimination of deviant (inappropriate) sexual arousal;
12. Trauma resolution in the event of personal victimization in the youth's own history;
13. Improved social skills and increased social competence and sense of self-efficacy and social mastery;
14. Development of relapse prevention plans that recognize situational, emotional, and cognitive factors that might contribute to a sexual reoffense, as well as defined methods to avoid high-risk situations and escape patterns of sexually inappropriate or otherwise antisocial behavior;
15. Improved family functioning in which family dysfunction, communication, attitudes, or roles contributing to or helping to maintain sexually aggressive, antisocial, or unhealthy behaviors are addressed and remediated;
16. Victim recognition and awareness with focus on the development of empathy and clarification of the harm caused to the victim and others;
17. Victim and community restitution in which the juvenile (sexual offender) undertakes reparation and makes amends."

To operationalize the aforementioned goals, each youth should achieve the following nine concrete objectives:

1. Understand, identify, and interrupt thoughts, feelings, beliefs and behaviors that contribute to abuse and all unhealthy choices and behaviors;
2. Develop responsibility for personal choices and behavior without minimization or justification;
3. Understand the impact of past trauma on self-image, functioning, difficulties and behaviors;
4. Develop awareness, sensitivity and compassion for others;
5. Learn and understand normative and inappropriate and/or unhealthy sexual development;
6. Identify, interrupt and control unhealthy and/or inappropriate sexual arousal, thoughts and fantasies;
7. Learn and use adaptive coping and social skills;
8. Build and engage in noncoercive relationships;
9. Develop and use healthy interventions and life skills to allow youth to successfully reenter a healthy developmental trajectory and build the competency, resiliency and protective factors necessary to resolve and/or eliminate etiological and maintenance factors, as well as achieve (in a healthy way) the needs and goods required to be happy and healthy and live a good life.

(Adapted from Rich, Phil, *Evaluation of Juvenile Sexual Offender and the Assessment of Risk*, Understanding, Assessing, and Rehabilitation Juvenile Sexual Offenders, John Wiley & Sons, Inc., 2003.)

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Contact and Reunification: "Empowering the Resolution Continuum"

When a youth is removed from his/her home due to sexual misconduct, all contact and communication should only occur under clinical supervision and should adhere to a structured protocol. Those treatment providers working with the sexually abusive youth and victim(s) should closely follow the standards and guidelines outlined in the NOJOS *"Resolution Continuum"* (RC) (2003). The RC is a structured guided step-by-step manual developed by NOJOS that aids clinicians in facilitating reunification, clarification, reintegration and resolution of the trauma and impact to families, victim(s), youthful offenders and communities caused by sexual offending. Reestablishing communication and contact should occur only as a therapeutic decision. Reunification decisions should be well thought out, clinically-guided and justified. NOJOS advocates that the RC guidelines and format be followed during all clarification, resolution, reintegration, and reunification, communication, sessions and procedures.

The following requirements are insisted upon and need to be followed during the use of the RC process for clarifying, resolving, reunifying youthful offenders with their victim(s), families and communities:

- The RC must be conducted and supervised by professionals skilled in working with sexual abuse treatment and dynamics.
- The sexually abusive youth, victim and all other participants must be assessed to determine if appropriate and if they can benefit from the process.
- The timeframe of when it should occur needs to be assessed. It is highly recommended that all individuals impacted or traumatized by the abuse should be involved in treatment during the RC process.
- All participants should be carefully prepared.
- Any communication between sexually abusive youth and victim(s) needs to be clinically facilitated, approved and monitored.
- All goals and interventions need to be focused on the needs and best interest of the victim(s), families and community.
- Clear goals and objectives should be established prior to any/all communication between sexually abusive youth and victim(s).
- Rights, feelings and desires of the victim and those impacted by the abuse are paramount and take first priority throughout the process.
- Rules for behavior and communication should be established to ensure the physical and emotional safety of the participants.
- The victim may cancel the communication at any time and for any reason. Victim comfort and sense of control must be maintained during all sessions.
- Debriefing and follow-up with the therapists and the group members are integral elements of the process for all participants.
- It is acceptable and appropriate for the victim to change his/her position from one communication to the next and to change his/her mind about anything that transpired during any previous communication.
- Communication must be cancelled, postponed, terminated and/or re-evaluated if they appear to be causing any re-victimization.

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- The clinician should remain tuned into any subtle intimidation or pressure on the victim, whether intentional or unintentional, by the sexually-abusive youth or other family members, including parents.
- Enough time is provided in each communication to cover all material relevant to that session.
- Communication is scheduled frequently enough to ensure that the victim clarification process moves along smoothly.

(Lamb, D. et al., *The NOJOS Resolution Continuum With Traumatized Children, Families, And Communities Through Clarification, Resolution, Reintegration, And Reunification With Perpetrators Of Abuse:* a step-by-step guide to clinical reunification of abuse survivors, families, communities, and offenders impacted by abuse, 2003; See also, Shladale, J., *A Collaborative Approach For Family Reconciliation And Reunification With Youth Who Have Caused Sexual Harm,* Knowledge & Practice-Challenges in the Treatment and Supervision of Sexual Abusers, Prescott, D.S., LICSW, Editor and Contributor, Wood 'N' Barnes Publishing, 2007, pages 239-279.)

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PROTOCOLS AND STANDARDS
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Level One:
In-Home / Outpatient Psychosexual Education

Client Profile:

Youth appropriate for a Level One intervention are typically in one of two categories:
1) Younger children and adolescents with no previous reported history of sexual acting out, or who have engaged in sexual misconduct on one occasion, or who have displayed low-frequency sexual behaviors. Sexual incidents are isolated, exploratory and/or situational in nature with no use of coercion or violence, and there is no evidence of progression of offense behavior; or
2) Adolescents who, in the course of normative (stable and serial*) "consensual, non-coercive" relationship, administer sexual touches or receive or perform sexual behaviors. However, based on the age or development of one of the parties, these behaviors are illegal (i.e. sixteen-year-old with a fourteen-year-old). Specifically, one party may not legally consent based on the legal definition of the age of consent. The problem must strictly lie in the issues of consent, not in equality or coercion.

Both categories of youth have typically had little exposure to healthy sexual information and experiences, present with low culpability and their sexual behavior tends to be less intrusive. They have little insight in the wrongness or consequences of their behavior. These youth may be impulsive having gained sexual information beyond their developmental readiness. Their sexual misconduct is usually as a result of deficits in their fund of sexual knowledge and consequences rather than distortions in their cognition or deviant sexual interests per se. These youth are a ***low risk*** to the community, as assessed by nationally-recognized risk-assessment tools, and the majority of them have a good parental support system that is fairly functional. These youth may or may not be adjudicated; however, adjudication may be helpful and is recommended to ensure compliance.

* Moral, social, and/or familial rules may restrict, but these behaviors are not *abnormal*, developmentally-harmful and/or illegal when private, consensual, equal and non-coercive. Stable monogamy is defined as a single sexual partner throughout adolescence. Serial monogamy indicates long-term (several months or years) involvement with a single sexual partner that may be preceded or followed by similar long term monogamous relationships (Ryan, G. and Lane, S. Editors; Juvenile Sexual Offending; Causes, Consequences, and Correction, Jossey-Bass Press, 1997).

Treatment Goals:

Level One programs include public and private community-based mental health programs that provide a short-term, age-appropriate collateral psycho-educational module on human sexuality and healthy human sexual behavior, including detailed material on sexual misconduct and child

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sexual abuse definitions, consequences and strategies for identifying, avoiding and coping with the contributing factors and risky sexual behavior situations (David S. Prescott and Robert E. Longo, *Current Perspectives: Working with Young People Who Sexually Abuse,* Current Perspectives: Working with Sexually Aggressive Youth & Youth With Sexual Behavior Problems, Longo, Robert E. & Prescott, David S., Editors, NEARI Press, 2006, page 51).

The primary goals of Level One treatment are to:

1. educate the youth to ensure that he or she understands what is appropriate versus inappropriate sexual behavior;
2. develop and/or augment a healthy fund of sexual knowledge;
3. enhance his or her responsible adaptive level of functioning socially, emotionally and sexually; and
4. place youth on (or back on) on normal developmental trajectory of sexual development.

Treatment Modalities and Frequency:

The primary treatment modalities are individual and family therapy, but can include a psychosexual education group. Treatment is weekly and short-term (approximately three to six months based on curriculum and the youth's need). Treatment includes homework (individual and family), journal assignments and parent involvement. Treatment interventions can include experiential exercises, sensory interventions, observation in the community, parent education, development of social skills and ongoing assessment of risk.

Targeted sex-specific treatment is contraindicated for Level One youth. Every effort should be made to avoid the "contagion effect" for these youth by ensuring that youth placed in a psychosexual educational group are similar in age, development and social ability, as well as sexual risk. For example, it would be inappropriate for a Level One youth to participate in a Level Two Sex-Specific Group (where detailed information about sexual-offense behavior is discussed) and/or be introduced to targeted sex-specific curriculum (i.e. Pathways, cycle work, etc). Treatment is more about aiding youth to understand their sexuality and sexual development, owning responsibility for their sexuality (thoughts, feelings and behavior), identifying that there are consequences for their choices and entering or reentering a normative developmental pathway for their sexuality.

Treatment Focus:

Group and individual/family therapy should be tailored to the individual client and incorporate the following as determined appropriate:

- Sex education (including maturation, sexual anatomy, sexual physiological responses, etc.);
- Sexuality education—recognition they are a sexual being and sexuality is a part of their life and current stage of development; that sex has meaning and purpose in life, and an understanding of what meaning sex plays in their life; and developing the competency to establish healthy sexual relationships (as defined by personal values);
- How to communicate effectively regarding sex and sexuality;

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- The distinction between healthy versus unhealthy sexual functioning and behavior;
- Developmentally-expected child/adolescent sexual behaviors and sexual development;
- Current abuse laws and consequences governing sexual behavior;
- Defining abuse and understanding impact;
- Accountability;
- Values clarification and healthy sexual attitudes;
- Self-esteem and healthy-identity development, including positive body image;
- Development of emotional and self-regulation;
- Identification and healthy expression of feelings;
- Anger management;
- Stress management and emotional-coping skills;
- Interpersonal boundaries;
- Empathy development; and/or
- Interpersonal relationship skills and assertiveness.

Treatment Providers:

Those individuals providing targeted sex-specific therapy interventions must be certified by NOJOS as a Sex-Specific provider with training in adolescent development, trauma and neurophysiology, as well as etiological and maintenance factors that impact developmental trajectory. However, if the psychosexual education is not provided by a licensed mental-health clinician, the individual must be trained and competent to provide the service and be supervised by a NOJOS Certified Sex-Specific Clinician.

Monitoring:

NOJOS Certified Sex-Specific clinicians and youth's parents/guardians monitor nonadjudicated youth while the Juvenile Court monitors adjudicated youth. Cases involving sibling incest may benefit from protective supervision by the Division of Child and Family Services (DCFS). Chaperones for youth who have engaged in sexual misconduct need to be approved by the NOJOS Certified Sex-Specific clinician(s). All chaperones/approved supervisors must be educated of the youth's risk factors in order to provide appropriate supervision.

Criteria for Discharge:

Criteria for treatment progress include, "Accomplishment of the specific treatment goals and objectives, cooperativeness in treatment, maintaining control and self-responsibility, changes in thinking, and observable changes of behavior over time" (National Task Force on Juvenile Sexual Offending, 1993, page 52). Ideally, each client should demonstrate increased understanding and fund of sexual knowledge regarding their sexuality and sexual development, responsibility for their sexuality (thoughts, feelings, and behavior), understanding of the consequences for their choices and evidence of entering or reentering a more normative developmental pathway for their sexuality and adolescent development.

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PROTOCOLS AND STANDARDS
FOR YOUTH WHO ENGAGE IN SEXUAL MISCONDUCT

Level Two:
In-Home / Outpatient Sex-Specific Psychotherapy

Client Profile:

Level Two youth not only need psychosexual information (as outlined in Level One), but they also present with a need for directed sex-specific clinical intervention. Typically, these youth are first-time offenders, or they may have successfully graduated from a higher level of care and need ongoing outpatient services for step-down transitional and aftercare purposes. These youth may present with a slightly greater frequency and duration of sexual misconduct than a Level One youth. They may have one or more victims, but typically do not have indiscriminate choice of victims (i.e., male and female victims, related/unrelated victims and/or toddler and peer victims). Their sexual behavior may have been more intrusive, but displays minimal evidence of progression from less-intrusive to more-intrusive sexual behaviors. Additionally, these youth typically meet one or all of the following: 1. lack of consent, which means one of the parties does not a) understand what is proposed without confusion or trickery; b) know the standard for sexual behavior in the culture, the family and the peer group; c) posses awareness of possible consequences including stigma, punishment, pain and disease; and d) have respect for the agreement or disagreement with out repercussions; and/or 2. a lack of equity between parties, meaning there is a inequality in the authority, power and control within the relationship; and/or 3. the presence of coercion, meaning pressure to comply (either explicit or implied) has been exerted in order to get someone else to do something (Ryan and Lane, 1997).

Overall, these youth are disclosing and acknowledge some accountability for their sexual misconduct. They generally display feelings of guilt or shame, although they do not always demonstrate empathy, either due to their developmental stage or lack of understanding of the impact on others, or they have barriers that have prevented the development of empathy. These youth typically present with adequate community support, are willing and able to comply with safety restrictions and are amenable to treatment. In limited circumstances, these youth may present with moderate risk; however, the youth's family or caregivers are able and willing to provide appropriate supervision and comply with treatment recommendations, and it is determined that this supervision provides an accepted protective factor to ameliorate risk of reoffense. These youth typically do not present with a strong patterns of oppositional behavior or conduct disorder; however, they may present with clinically-significant depressive symptoms, anxiety and/or impulsivity/attention problems. The majority of Level Two youth are ***low and/or low-to-moderate risk*** as assessed by nationally recognized risk assessment tools.

Adjudication is strongly recommended. Few providers, if any, will treat this population on an outpatient basis without Court involvement.

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The significant difference between Level Two and Level Three and Level Four youth lies in the protective factors, resiliency and internal and external assets of the youth. Level Two youth present with more protective factors internally, as well as in their environmental and family functioning and school functioning—they also have higher levels of resiliency and internal assets that act to lower or offset their risk to offend. Further, Level Two youth, based on clinical assessment, are able to be managed safely in their home environment and traditional school setting.

Treatment Goals:

Level Two programs should provide individual, group and/or family therapy offering traditional adjunct mental-health services (with variations in focus, model, and duration) and sex-specific services. These programs should provide abuse-specific interventions, cognitive-behavioral content, risk management, and strength-based skill building (Positive Psychology). Sex-specific treatment also often includes modules based on relapse prevention, increasing self-monitoring of behavior, understanding thoughts, feelings, behaviors and consequences associated with sexual misconduct, and strategies for managing inappropriate sexual behavior, etc. (David S. Prescott and Robert E. Longo, *Current Perspectives: Working with Young People Who Sexually Abuse,* Current Perspectives: Working with Sexually Aggressive Youth & Youth With Sexual Behavior Problems, Longo, Robert E. & Prescott, David S., Editors, NEARI Press, 2006, page 52).

As mentioned previously, the National Task Force on Juvenile Sexual Offending (1993) has identified certain definable sex-specific treatment issues or goals. These goals include increases in the youth's adaptive levels of functioning behaviorally, emotionally, socially, cognitively and psychologically. In addition to these goals, the youth should improve their executive functioning, social competency and relatedness, use of social skills in demonstrating mastery in their environment, as well as stabilization of behavior in social, school and home setting.

Overall, the goal is to assist the youth to increase competency and skills necessary to ensure their ability to control or eliminate etiological and maintenance factors influencing their pathway to offend, reestablish a healthy developmental trajectory (in all developmental stages), obtain their needs and human goods in a healthy way and place themselves back on a healthy pathway towards becoming a functional, healthy and happy adult (Ward, T.; Polaschek, D. and Beech, A. Theories of Sexual Offending, John Wiley & Sons, Ltd. 2006).

A full list of Sex-Specific Treatment Goals is presented above on pages 9 - 11.

Treatment Modalities and Frequency:

Based on the youth's presenting problems and needs assessment, Level Two treatment can vary in focus, intensity, duration and frequency. Nevertheless, Level Two treatment must include targeted sex-specific therapy and psychosexual education, as well as adjunct with traditional mental-health therapy. However, in some circumstances some youth may only need traditional non-sex-specific therapy with adjunct Level One Psychosexual Education. Further, in circumstances where the youth presents as vulnerable and naïve (i.e. low ego strength, extremely immature, etc.), group intervention may not be beneficial and/or appropriate.

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The primary Level Two treatment modalities include individual/family, group and parent-group sessions. At a minimum, individual and targeted sex-specific group sessions should occur weekly. In some circumstances, based on the youth's needs, it may be necessary for a youth to participate in more intensive sex-specific outpatient services to include two to three sex-specific sessions per week. (*Parent groups and family therapy should occur at least bimonthly.) Family therapy should focus on family dynamics associated with the youth's misconduct and/or problematic functioning, as well as supervision, safety and assisting the youth to manage his/her risk. Family therapy should also include education of the parents/caregivers regarding the youth's current risk factors, treatment goals and supervision needs. It is important to view the parent/guardian as part of the treatment team and empower them to be an active participant in the youth's treatment. If there is a greater degree of conflict or problems in the youth's home environment, more frequent and/or intensive family therapy should occur focused specifically on these family issues. Additionally, Level Two youth may require psychiatric/medication management services, skills development services and/or psychological services.

*Given that some youth may not have parents, when the term "parent" is used it includes the youth's parents, caregiver, and/or primary-support system.

Treatment Providers:

Those individuals providing targeted sex-specific therapy interventions (whether it is individual, family or group therapy), should be certified by NOJOS as a Sex-Specific provider. Individuals providing trauma-specific treatment (whether it is individual or group therapy), should be licensed mental-health clinicians with some experience and training in working with youth who have been traumatized. Sex-Specific treatment providers should have training in understanding adolescent development and trauma, as well as neurophysiology and etiological (including maintenance factors) impact on developmental trajectory. They also need to be aware of the influence of family, environment, social and culture on the youth.

Monitoring:

Ideally, all Level Two youth should be referred to the Juvenile Court for delinquency (not just dependency). Court involvement provides additional supervision for community protection and sanction supporting youth accountability. The juvenile justice authority and/or DCFS/DJJS treatment team, in conjunction with the NOJOS Certified Sex-Specific clinician(s), act as a clinical intervention team to ensure the youth's compliance and progress in the treatment program. Chaperones for youth who have engaged in sexual misconduct need to be approved by the NOJOS Certified Sex-Specific clinician(s). All chaperones must be educated about the youth's risk factors in order to provide appropriate supervision. A safety plan and/or supervision guidelines are recommended to be implemented in the youth's home to ensure environmental and community safety. Guidelines should include those adults who have been approved to supervise the youth, contact restrictions (if any), restrictions around bathroom use, hygiene practices (bathing, dressing, etc.), nighttime routines, caretaking responsibilities and involvement in, and supervision of, extracurricular activities.

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Criteria for Discharge:

The NOJOS Certified Sex-Specific clinician(s) and the treatment monitoring team evaluate the youth's treatment progress. Criteria for treatment progress include: "accomplishment of the specific treatment goals and objectives, cooperativeness in treatment, maintaining control and self-responsibility, changes in thinking, and observable changes of behavior over time" (National Task Force on Juvenile Sexual Offending, 1993, p. 52). The youth should also demonstrate increased competency and skills necessary to ensure their ability to control or eliminate etiological and maintenance factors influencing their pathway to offend, reestablish a healthy developmental trajectory (in all developmental stages); to obtain their needs and human goods in a healthy way; and place themselves back on a healthy pathway towards becoming a functional, healthy, happy adult (Ward, T.; Polaschek, D. and Beech, A. Theories of Sexual Offending, John Wiley & Sons, Ltd. 2006).

The National Task Force on Juvenile Sexual Offending also identified specific treatment progress indicators in their revised report (1993). Adaptations of these guidelines include:

1. Understand, identify, and interrupt thoughts, feelings, beliefs, and behaviors that contribute to abuse and all unhealthy choices and behaviors;
2. Develop responsibility for personal choices and behavior without minimization or justification;
3. Understand the impact of past trauma on self-image, functioning, difficulties, and behaviors;
4. Develop awareness, sensitivity, and compassion for others;
5. Learn and understand how to differentiate normative and unhealthy sexual development;
6. Identify, interrupt and control, unhealthy and/ or inappropriate sexual arousal, thoughts, and fantasies;
7. Learn and use adaptive coping and social skills;
8. Build and engage in noncoercive, reciprocal relationships; and
9. Develop and demonstrate effective use of self management strategies and a relapse prevention plan.

The client's self-regulation/relapse prevention plan must include identification of personal risk factors and knowledge of community resources in case of a relapse. Youth who are uncooperative with treatment, deny or minimize sexually-abusive behaviors, resist treatment intervention, are unable or are unwilling to comply with treatment recommendations and/or identify and manage risks, or continue to exhibit sexually inappropriate behavior, will require additional intervention. It may be also be appropriate to refer such youth to a more intensive/restrictive level of treatment and supervision. However, while all the above potentially indicate that the youth's risk has increased, a reassessment of the youth's risk and current Level of treatment should be conducted. Further, all changes in placement or clinical level should be based on increased or decreased risk as measured by nationally accepted risk assessment tools rather than *solely* on resistance and/or noncompliance.

It is recommended that Level Two youth undergo a discharge assessment to determine if:

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1. Co-morbid issues have been addressed/stabilized;
2. Risk has been lowered;
3. Level of functioning/skills have improved;
4. A stable support system has been developed;
5. Etiological and maintenance factors, as well as treatment issues identified in the intake assessment, have been addressed;
6. Protective factors, resiliency, internal and external assets have been increased; and
7. Progress has occurred on sex-specific treatment goals.

As detailed in the NOJOS Assessment Protocol an updated sex-specific assessment is recommended prior to any discharge or step-up or step-down in the NOJOS continuum.

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Level Three: Sex-Specific Day Treatment

Client Profile:

Those youth appropriate for Level Three intervention differ from Level Two youth in that they present deficits in executive functioning and psychosocial stressors with peers. They also require more management in their school and/or home environment. Deficits in executive functioning are evidenced by: difficulties in emotional regulation; behavioral self regulation; limited internal rules for social behavior and interaction; poorly defined sense of boundaries and taboos; failure to understand consequences of their behavior; limited internal control over hyperactivity, emotions and impulsivity; inflexibility in the environment; attention and concentration deficits; poor planning and abstract thinking; and aggression. Executive functioning deficits may also be marked by behavior problems and oppositional and defiant conduct. These youth often have a prior history of behavioral problems in their home and/or school. They also have frequently received diagnoses of attention deficit or impulsivity (ADHD), learning disabilities (LD), and/or behavior disorders (BD) requiring additional supervision in their school setting. Further, many of these youth have social-competency and social-relatedness deficits that affect their ability to master the skills necessary to succeed in their social environments. Additionally, many of these youth have preexisting co-morbid mental health issues and may have been in treatment prior to engaging in sexual misconduct.

Level Three youth may have similar sexual patterns and issues as a Level Two youth, but they exhibit more extensive behavioral and emotional problems necessitating greater structure during the day (traditional school and after-school hours). These youth may present with a severe and repetitive pattern or executive-functioning deficits highlighted by aggressive or self-destructive behavior OR learning difficulties/disabilities, cognitive limitations or thought disorder (stabilized on medications). As a result, these youth require a more intensive therapeutic approach than a Level Two intervention. These youth may be slightly more sexually preoccupied than a Level Two youth; however, the preoccupation is generalized and impulsive rather than sexually-deviant. They typically present as more socially awkward or inept and have a higher degree of mental-health issues. These youth also usually present with significant impulsivity issues that have not been adequately managed in a traditional school setting.

Youth appropriate for Level Three Sex-Specific Day Treatment are rated a ***low-to-moderate or moderate risk*** as assessed by nationally recognized risk assessment tools. Due to their deficits in executive functioning, resulting poor self regulation and preexisting behavioral and emotional problems, these youth present a higher risk to fail in treatment and school at a lower level of care. Accordingly, a traditional school setting (defined as mainstream classes) is <u>contraindicated</u>. However, these youth may attend mainstream school, after a risk assessment is completed that indicates the youth's risk has been lowered to an acceptable level and/or can be controlled in a traditional mainstream school setting.*

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Youth placed in Level Three Sex-Specific Day Treatment may include Level Two youth that live in their own home, Level Four and Five youth that are in the custody of the State and placed in foster/proctor homes, sex-specific group homes and independent-living programs. However, every effort should be made to avoid the "contagion effect" and ensure that youth placed in Day Treatment programming are similar in age, development and social ability, as well as sexual risk (i.e. lower functioning youth should not be placed in a more general milieu). Adjudication is strongly recommended to ensure compliance.

* These youth can attend regular school; however, they should be placed in a classroom setting designed to deal their unique emotional, behavioral, social and academic difficulties. These youth will also typically require an individualized education plan (IEP).

Treatment Goals:

As mentioned previously, the National Task Force on Juvenile Sexual Offending (1993) has identified certain definable sex-specific treatment issues or goals. These goals include increases in the youth's adaptive levels of functioning behaviorally, emotionally, socially, cognitively and psychologically. In addition to these goals, the youth should improve their executive functioning, social competency and relatedness, use of social skills in demonstrating mastery in their environment and stabilization of behavior in social, school and home setting.

Overall, the goal is to assist the youth to increase competency and skills necessary to ensure their ability to control or eliminate etiological and maintenance factors influencing their pathway to offend, reestablish a healthy developmental trajectory (in all developmental stages), obtain their needs and human goods in a healthy way and place themselves back on a healthy pathway towards becoming a functional, healthy and happy adult (Ward, T.; Polaschek, D. and Beech, A. Theories of Sexual Offending, John Wiley & Sons, Ltd. 2006).

A full list of Sex-Specific Treatment Goals is presented above on pages 12 - 13.

Treatment Modalities and Frequency:

In most cases Level Three Sex-Specific Day Treatment programs are attached to community mental-health agencies, residential and inpatient setting; however, Level Three youth do not reside there, they merely participate in the treatment milieu and daily programming. After participating in Sex-Specific Day Treatment each day, they either return to their own home, foster/proctor home, group home, independent living setting or residential setting in the evenings and on weekends. Level Three programs usually incorporate specialized academic classroom schooling/vocational training and therapeutic components similar to those found in residential programs (David S. Prescott and Robert E. Longo, *Current Perspectives: Working with Young People Who Sexually Abuse,* Current Perspectives: Working with Sexually Aggressive Youth & Youth With Sexual Behavior Problems, Longo, Robert E. & Prescott, David S., Editors, NEARI Press, 2006, page 52).

Level Three Sex-Specific Day Treatment programming occurs five days weekly, including daily targeted sex-specific intervention. The youth also participates in sex-specific therapy modalities

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(individual therapy, group therapy and family therapy) as outlined in Level Two (See pages 20-21). Treatment is also comprised of psychosexual education curriculum and daily skills-development services. In conjunction with the sex-specific therapy, treatment modalities are included to aid the youth in learning self-regulation and emotional coping skills, skills development and behavior management.

Level Three Sex-Specific Day Treatment programming can also be used in conjunction with Level Four Proctor/Foster Care and Level Five Sex-Specific Group Home treatment programs. For example, some Level Four and Level Five youth attend Level Three Sex-Specific Day Treatment programming for their educational, psychosocial and behavioral needs, coupled with more intensified residential-level sex-specific therapies.

Treatment Providers:

Those individuals providing targeted sex-specific therapy interventions, whether it is individual, family or group therapy, should be certified by NOJOS as a Sex-Specific provider. Individuals providing trauma-specific treatment, whether it is individual/group therapy, should be licensed mental health clinicians with some experience and training in working with youth who have been traumatized. Sex-Specific treatment providers should have training in understanding adolescent development and trauma, as well as neurophysiology and etiological (including maintenance factors) impact on developmental trajectory. They also need to be aware of the influence of family, environment, social and culture on the youth.

Those individuals providing skills-development services or other skills based groups (i.e. anger/aggression, mood management, prosocial skills, etc.) must be trained and competent to provide the service; however, although they are not required to have a clinical license or be certified by NOJOS, it is recommended that they have attended and completed the NOJOS Basic Line Staff Training. Regardless, providers of these adjunct services should work under the supervision of a NOJOS Certified Sex-Specific Clinician.

Monitoring:

Ideally, all Level Three youth should be referred to the Juvenile Court for delinquency (not just dependency). Court involvement provides additional supervision for community protection and sanction supporting youth accountability. The juvenile justice authority and/or DCFS/Division of Juvenile Justice Services (DJJS) treatment team, in conjunction with the NOJOS Certified Sex-Specific clinician(s), act as a clinical intervention team to ensure the youth's compliance and progress in the treatment program. Chaperones for youth who have engaged in sexual misconduct need to be approved by the NOJOS Certified Sex-Specific clinician(s). All chaperones must be educated about the youth's risk factors in order to provide appropriate supervision. A safety plan and/or supervision guidelines are recommended to be implemented in the youth's home to ensure environmental and community safety. Guidelines should include those adults who have been approved to supervise the youth, contact restrictions (if any), restrictions around bathroom use, hygiene practices (bathing, dressing, etc.), nighttime routines, caretaking responsibilities and involvement in (and supervision of) extracurricular activities.

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Criteria for Discharge:

The NOJOS Certified Sex-Specific Clinician(s) and the juvenile justice monitoring team evaluate the youth's treatment progress. Criteria for treatment progress include: "accomplishment of the specific treatment goals and objectives, cooperativeness in treatment, maintaining control and self-responsibility, changes in thinking and observable changes of behavior over time" (The Revised Report from the National Task Force on Juvenile Sexual Offending, 1993 of The National Adolescent Perpetrator Network, *Juvenile and Family Court Journal*, 1993, Vol. 44, No. 4, page 52.] The progress indicators established by the National Task Force on Juvenile Sexual Offending 1993 are also useful to evaluate treatment progress (page 52). (See summary on page 22 above).

Level Three Sex-Specific Day Treatment has an indeterminate length, as it is partially dictated by the calendar school year and the varying needs of the youth. As deemed appropriate, once a youth successfully completes Level Three Sex-Specific Day Treatment programming, a step-down to Level Two sex-specific outpatient treatment or a referral to traditional mental-health services may be appropriate. As in any treatment level, lack of treatment progress may result in a referral to a more-intensive treatment intervention. However, as stated above <u>all</u> changes in placement or clinical level should be based on increased or decreased risk as measured by nationally accepted risk assessment tools rather than *solely* on resistance and/or noncompliance.

It is recommended that Level Three youth undergo a discharge assessment to determine if:

1. Co-morbid issues have been addressed/stabilized;
2. Risk has been lowered;
3. Level of functioning/skills have improved;
4. A stable support system has been developed;
5. Etiological and maintenance factors, as well as treatment issues identified in the intake assessment, have been addressed;
6. Protective factors, resiliency and internal and external assets have been increased; and
7. Progress has occurred on sex-specific treatment goals.

As detailed in the NOJOS Assessment Protocol, an updated sex-specific assessment is recommended prior to any discharge or step-up or step-down in the NOJOS continuum.

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Level Four: Sex-Specific Proctor or Foster Home / Outpatient Sex-Specific Psychotherapy

Client Profile:

Youth appropriate for Level Four Proctor/Foster Care either present with: (1) a risk that cannot be controlled in their current living environment; and/or (2) parents and caregivers who cannot provide adequate supervision; and/or (3) parents/caregivers who do not provide an adequate, healthy or safe living environment for the youth. The youth's environmental risks may include immediate or near-immediate access to victim(s) or potential victim(s), thus, rendering it as inappropriate. Further, the youth may not be able to continue residing at home because the sibling victim(s), and/or other victim(s) also residing in the home, need separation from the sexually-abusive youth to begin their healing process. A youth's removal from home is also necessary at times when the parent/guardian's denial/minimization of current risk is present, or they do not adequately understand or respect current risk of the youth such that it impacts their ability/willingness to provide adequate supervision. The youth may also present with deficits in executive functioning resulting in their inability to self-regulate sexual and/or nonsexual acting-out behaviors, and/or need behavioral modification or skill enhancement interventions that cannot be provided in their home environment (i.e. milieu clinical intervention).

Youth transitioning down from a higher level of care are also appropriate for a level Four placement as a step-down option. In this situation, this level of care provides a less-restrictive environment for transition and practice of skills learned in more-intensive residential and/or secure care settings. Level Four also includes youth who are failing, or who have failed, at a lower level of placement on the NOJOS Continuum of Care (i.e., Levels One, Two and Three). However, to qualify for a Level Four placement, the failure is typically a result of environmental or familial issues rather than related to the youth's conduct or increase in risk. Furthermore, it is recommended that youth who fail at a Level Two intervention because of their conduct, resulting in an increase in their risk, be placed in either a Level Five or Level Six setting (Level Six being preferred).

Level Four youth should be charged and adjudicated for their sexual delinquency in the Juvenile Court. The majority of Level Four youth are Court ordered into State's custody under the supervision of DCFS or DJJS who will provide, or who will contract with providers, sex-specific placement and treatment services. DCFS typically utilizes foster-home placements, and DJJS utilizes proctor-home placements.

Level Four Proctor/Foster Care is typically the first out-of-home alternative available on the NOJOS Continuum of Care. Specifically, Level Four youth require more-intensive structure and supervision than what is available in their current home environment—and/or the youth is in

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need of a transitional placement to practice, generalize and apply the skills learned in a more-structured environment. Level Four youth typically present as a ***moderate risk*** to the community as assessed by nationally recognized risk assessment tools. Level four youth are in need of a placement based on issues within their environment, and thus, appropriateness for placement in Level 4 is based on the following criteria:

1. Deficits or issues within the home environment:
   a. Is marked by extreme stress or instability, and it is determined that this stress and instability will not provide the support or supervision the youth needs to address his or her treatment and/or supervision needs;
   a. The adults are incapable of, or choose not to, provide the level of structure and supervision required to prevent reoffense or assist the youth to deal with his/her treatment needs;
   b. The family, through their own behaviors, values and issues, does not provide a healthy environment for youth to heal;
   c. The family presents as enabling and/or denial-based;
   d. The family does not possess the skills or resources necessary to address the youth's clinical needs (i.e. skills enhancement, behavioral modification, regulation of co-morbid mental health issues, regulation of impulsivity, emotions, and behaviors).

2. Additionally, those youth who have successfully completed a higher level of care, such as a Level Six or Level Eight, may transition (step-down) to a Proctor/Foster care setting, where they receive structure and supervision and are able to continue aftercare outpatient sex-specific treatment.

Level Four Proctor/Foster care homes must cater to the youth's sexual risk to ensure that the youth is placed with others similar in age and maturity and is <u>not</u> placed with children similar in age to the youth's victim(s), and/or potential/possible victims and/or older offending youth (which could subject the youth to contagion and/or risk of being victimized). Level Four Proctor/Foster homes should AT MOST have one or two additional proctor/foster siblings in the same household. If the youth presents a risk to those younger than himself/herself, he or she should <u>not</u> be placed in a foster/proctor home with younger children or peers. If the youth presents a risk to same-age peers and younger children, the youth must be placed in a foster/proctor home with no other children. The youth's risk must be assessed prior to placement to avoid inappropriate placement—especially when there is a potential risk of reoffending.

Treatment Goals:

Level Four youth must participate in, and successfully complete, adjunct Level Two and/or Level Three sex-specific treatment as specified in these Protocols and Standards above (See pages 20-21, 25-26).

As mentioned previously, the National Task Force on Juvenile Sexual Offending (1993) has identified certain definable sex-specific treatment issues or goals. These goals include increases in the youth's adaptive levels of functioning behaviorally, emotionally, socially, cognitively and

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psychologically. In addition to these goals, the youth should improve their executive functioning, social competency and relatedness, use of social skills in demonstrating mastery in their environment and stabilization of behavior in social, school and home setting.

Overall, the goal is to assist the youth to increase competency and skills necessary to ensure their ability to control or eliminate etiological and maintenance factors influencing their pathway to offend, reestablish a healthy developmental trajectory (in all developmental stages), obtain their needs and human goods in a healthy way and place themselves back on a healthy pathway towards becoming a functional, healthy and happy adult (Ward, T.; Polaschek, D. and Beech, A. Theories of Sexual Offending, John Wiley & Sons, Ltd. 2006).

A full list of Sex-Specific Treatment Goals is presented above on pages 12 - 13.

Treatment Modalities and Frequency:

Level Four youth participate in Level Two and/or Level Three treatment provided by a contracted NOJOS Certified Sex-Specific Clinician (see pages 20- 21 above for Level Two and pages 25-26 for Level Three treatment modalities and frequency). Depending on current risk level, as well as the youth's presenting problems and needs, Level Four youth may attend school in a self-contained classroom such as Youth In Custody (YIC), Behavior Disordered (BD) classrooms or Level Three Sex-Specific Day Treatment educational programming. These youth may also attend mainstream school; however, ***only*** after a risk assessment is completed and indicates that the youth's risk is lowered to an acceptable level and/or can be controlled in a traditional mainstream school setting. Additionally, Level Four youth may require psychiatric/medication management services, skills-development services and/or psychological services.

Treatment Providers:

Those individuals providing targeted sex-specific therapy interventions (whether it is individual, family or group therapy), should be certified by NOJOS as a Sex-Specific provider. Individuals providing trauma-specific treatment (whether it is individual or group therapy), should be licensed mental-health clinicians with some experience and training in working with youth who have been traumatized. Sex-Specific treatment providers should have training in understanding adolescent development and trauma, as well as neurophysiology and etiological (including maintenance factors) impact on developmental trajectory. They also need to be aware of the influence of family, environment, social and culture on the youth.

Those individuals providing skills-development services or other skills based groups (i.e. anger/aggression, mood management, prosocial skills, etc.) must be trained and competent to provide the service; however, although they are not required to have a clinical license or be certified by NOJOS, it is recommended that they have attended and completed the NOJOS Basic Line Staff Training. Regardless, providers of these adjunct services should work under the supervision of a NOJOS Certified Sex-Specific Clinician.

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Individuals providing foster or proctor care for youth with sexual-behavioral problems must complete all pre-service training as required by the State Licensure and Department of Human Services requirements. They must also complete all other annual training as required by the State. In addition, these parents must complete a minimum of twelve hours of training annually specifically focused on understanding and working with youth with sexual issues and sexual-behavioral problems. This training must include information regarding appropriate supervision techniques to be utilized with sexually-traumatized youth, hyper-sexualized youth and youth who engage in sexual misconduct. These individuals must also attend and complete the NOJOS Basic Line Staff Training. Individuals providing Foster or Proctor Care must also be supervised by a Certified NOJOS Sex-Specific Clinician. Foster and Proctor Parents should be active participants in treatment-team meetings, and where applicable, should attend monthly Division team meetings.

Trackers of youth with sexual issues should meet all State Licensing and training requirements. They must complete twelve hours of training annually specifically focused on understanding and working with youth with sexual-behavioral problems. This training must include information regarding appropriate supervision techniques to be utilized with sexualized youth and youth who engage in sexual misconduct. These individuals must also attend and complete the NOJOS Basic Line Staff Training and be supervised by a NOJOS Certified Sex-Specific Clinician. It is also recommended that trackers are active participants in treatment-team meetings, and where applicable, should attend monthly Division team meetings.

Monitoring:

The majority of Level Four youth are in Department of Human Services' custody with either DCFS or DJJS. The Division case manager, along with the NOJOS Certified Sex-Specific Clinician and proctor/foster parents, work together to monitor the youth's compliance at home, school and in their sex-specific therapy. Additionally, in some cases, Level Four youth receive additional tracking services to increase monitoring and social support. If/when the youth's family is actively involved in the youth's care, and especially when the youth is to be eventually reunified with their family of origin, the parent(s)/guardian(s) must be involved in the treatment process. The parent(s)/guardian(s) may also provide supervision for the youth as deemed appropriate and approved by the NOJOS Certified Clinician and Division case manager once the family is educated on the youth's risk and supervision needs and a family safety and supervision guideline plan has been developed.

Criteria for Discharge:

The youth may be successfully discharged from proctor/foster care when the NOJOS Certified Sex-Specific Clinician, parent(s)/guardian(s) and Division case manager determine that the youth's problem behaviors are manageable in a less-restrictive setting and the family is able and willing to provide adequate supervision. Parent(s)/Guardian(s) must demonstrate they can provide adequate supervision before the youth can be returned to their care. Transfer to a Level Two outpatient sex-specific treatment program can allow the youth to continue to address sex-specific treatment goals. Treatment professionals should be careful to coordinate the transfer of treatment services and keep parents adequately informed.

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As in any treatment level, lack of treatment progress may result in a referral to a more-intensive treatment intervention; however, as stated above, all changes in placement or clinical level should be based on increased or decreased risk as measured by nationally accepted risk assessment tools rather than *solely* on resistance and/or noncompliance.

It is recommended that Level Four youth undergo a discharge assessment to determine if:

1. Family issues and environmental risk factors have been stabilized and/or reduced;
2. A stable support system has been developed;
3. Co-morbid issues have been addressed/stabilized;
4. Risk has been lowered;
5. Level of functioning/skills have improved;
6. Etiological and maintenance factors, as well as treatment issues identified in the intake assessment, have been addressed;
7. Protective factors, resiliency, internal and external assets have been increased; and
8. Progress has occurred on sex-specific treatment goals.

The progress indicators established by the National Task Force on Juvenile Sexual Offending are also useful to evaluate treatment progress (The Revised Report from the National Task Force on Juvenile Sexual Offending, 1993 of The National Adolescent Perpetrator Network, *Juvenile and Family Court Journal*, 1993, Vol. 44, No. 4, page 52) (See summary on page 22 above).

As detailed in the NOJOS Assessment Protocol, an updated sex-specific assessment is recommended prior to any discharge or step-up or step-down in the NOJOS continuum.

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Level Five
Sex-Specific Group Home or Independent Living / Sex-Specific Treatment

Client Profile:

Level Five youth present as ***moderate risk*** as assessed by nationally-recognized risk-assessment tools and includes two categories: Sex-Specific Group Home and Independent Living.

- ***Sex-Specific Group Home***

Level Five Sex-Specific Group Home intervention provides targeted sex-specific treatment in a therapeutic group-home setting. The primary differences between a Level Four Proctor/Foster Home and a Level Five Sex-Specific Group Home or Independent Living program is the intensity of therapy, increased opportunity for milieu intervention and increased supervision. Level Five programs provide additional clinical services, as well as twenty-four hour (awake) supervision and intervention.

Those youth who have successfully completed a higher level of care, such as a Level Six or Level Eight, may transition to a Sex-Specific Group Home or Independent Living setting, where they continue to be monitored in a structured setting and receive intensive targeted sex-specific treatment.

Clinicians must observe special precautions when they select youth for Level Five Sex-Specific treatment and supervision. The client profile for youth placed in a Level Five Sex-Specific Group Home is similar to that of a Level Four youth, with some important distinctions, as outlined below:

Those factors SIMILAR to Level Four youth in that there are deficits and problems in the home environment:

1. Deficits or issues within the home environment:
   a. Family system and/or home environment is marked by extreme stress or instability, and it is determined that this stress and instability will not provide the support or supervision the youth needs to address his or her treatment and/or supervision needs;
   b. The adults are incapable of, or choose not to, provide the level of structure and supervision required to prevent reoffense or assist the youth to deal with his/her treatment needs;
   c. The family through their own behaviors, values and issues does not provide a healthy environment for youth to heal;
   d. The family presents as enabling and/or denial-based;

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e. The family does not possess the skills or resources necessary to address the youth's clinical needs (i.e. skills enhancement, behavioral modification, regulation of co-morbid mental health issues, regulation of impulsivity, emotions, and behaviors).

Those factors that DIFFER from a Level Four youth:

1. The youth not only needs removal from their home environment due to environmental and family risk factors, but also present with greater problems and deficits in executive functioning and behavior management;
2. These youth are also under-socialized, or have social-competency issues and social-relatedness issues, and have difficulty in developing the skills necessary to master and be successful in their environment. These deficits require a Sex-Specific Group Home setting and peer milieu to learn prosocialization and healthy social skills. The Group Home setting is also necessary to provide the youth more structured opportunities to practice, improve and generalize new skills;
3. Less-developmentally mature than a Level Six youth, meaning their developmental - maturity level would place them at-risk in a Level Six program.;
4. Present as more amenable or receptive to treatment than a Level Six youth;
5. Present with difficult temperament traits. "Temperament" is defined as characteristics that describe the "how" of behavior—that is, how the individual behaves as opposed to what the behavior is or why the behavior occurs. Difficulty in temperament is marked by:
    a. Unmanaged or uncontrolled activity (the typical motor level, for example, restlessness or impulsivity);
    b. Uncontrolled intensity (level of regularity, predictability);
    c. Unpredictable rhythmicity (level of regularity, predictability);
    d. Difficulty with adaptability (response to newness or change, adjustment);
    e. Lowered threshold (level at which stimulation evokes a response);
    f. Persistence (level of attention or pursuit despite obstacles);
    g. Distraction (level at which stimuli interrupt or redirect attention);
    h. Responsivity (approach or withdrawal patterns regarding newness and change);
    i. Negative Mood (typical affective-state-positive, negative, or neutral);

    (Ryan and Lane, 1997)
6. History of, and/or current, behavioral-management issues in their home and/or school environment—unmanageability cannot be controlled in a less-structured environment. A behavioral-management program is required;
7. Under-socialized and/or multiple social competency deficits;
8. Self-harm behaviors;
9. Difficulties with executive functioning that require a peer milieu to learn control and self regulation.

- ***Sex-Specific Independent Living***

Level Five youth who qualify for a Sex-Specific Independent Living program present with sexual behavioral issues and are typically older adolescents in need of a transitional placement to assist them to transition directly into adult living. Sex-Specific Independent Living programming should specifically assist these youth to integrate and generalize their newly-

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acquired skills, or to develop such skills, to live independently in the community. These are youth who are either transitioning from a higher, more structured NOJOS level of treatment, or are youth without familial support from a Level Two program who need to learn to live independently. Prior to placement, risk must be reassessed to determine that independent living in the community is appropriate.

Treatment Goals:

Overall, the treatment goals for this level are those identified by the National Task Force on Juvenile Sexual Offending (1993). These goals include increases in the youth's adaptive levels of functioning behaviorally, emotionally, socially, cognitively and psychologically, while lowering risk of sexual reoffense. In addition to these goals, the youth should improve their executive functioning, social competency and relatedness, use of social skills in demonstrating mastery in their environment, and stabilization of behavior in social, school and home setting.

This Level also includes youth who have participated in a sex-specific treatment program and have been successful to the point they now need to integrate their new competencies and skills into an independent living setting and healthy emancipation.

Overall, the goal is to assist the youth to increase competency and skills necessary to ensure their ability to control or eliminate etiological and maintenance factors influencing their pathway to offend, reestablish a healthy developmental trajectory (in all developmental stages), obtain their needs and human goods in a healthy way, and place themselves back on a healthy pathway towards becoming a functional, healthy, happy adult (Ward, T.; Polaschek, D. and Beech, A. Theories of Sexual Offending, John Wiley & Sons, Ltd. 2006).

A full list of Sex-Specific Treatment Goals is presented above on pages 12 - 13.

Sex-Specific Group Home

The focus of a Level Five Sex-Specific Group Home treatment program is to provide primary sex-specific treatment similar to a Level Two treatment frequency and modality. However, it provides adjunct mental-health treatment and social skills services to address pre-existing mental health issues and psychosocial problems, and to provide prosocial skills training to increase social competence. Level Five group homes also provide a structure and therapeutic milieu that address the youth's individual issues and need for prosocialization through guided peer interaction and milieu intervention. Level Five Sex-Specific Group Home settings specifically help these youth learn to regulate their behaviors and emotions, control impulses, make healthy choices, learn consequences for unhealthy choices, increase personal accountability and become more socially competent.

Sex-Specific Independent Living

The treatment focus for Sex-Specific Independent Living is to aid the youth to develop independent and adult-living skills, such that they can successfully reintegrate into the community and establish a healthy support system. Often times this includes providing therapeutic assistance to help the youth individuate from parent(s)/guardian(s) and solidify a healthy young-adult identity.

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Treatment Modalities and Frequency:

Sex-Specific Group Home

Overall, treatment objectives should be holistic and include specific goals, tasks, and methods to address the youth's sex-specific, co-morbid and skills-development services. Sex-Specific Group Home programs are required to provide specialized sex-specific supervision and treatment; however, the frequency and intensity varies based on the population served and the individual need of each youth. In general, Level Five youth are required to complete sex-specific treatment more intensive than what is provided on a Level Two outpatient basis; however, the intensity of this regime is based on individual needs. Nevertheless, Level Five programming should include targeted sex-specific treatment (individual, family and group therapies), competency and skills development services and traditional mental health counseling, as well as medication management services.

*Parent groups and family therapy should occur at least bimonthly. Family therapy should focus on family dynamics associated with the youth's misconduct and/or problematic functioning, as well as supervision, safety and assisting the youth to manage his/her risk. Family therapy should also include education of the parents/caregivers regarding the youth's current risk factors, treatment goals and supervision needs. It is important to view the parent/guardian as part of the treatment team and empower them to be an active participant in the youth's treatment. If there is a greater degree of conflict or problems in the youth's home environment, more frequent and/or intensive family therapy should occur focused specifically on these family issues.

*Given that some youth may not have parents, when the term "parent" is used it includes the youth's parents, caregiver, and/or primary support system.

School programming should be based on the youth's risk to the community and his/her educational needs (i.e. may include Sex-Specific Day Treatment, Youth-In-Custody (YIC) classroom, Behavior Disorder (BD), public school, etc.).

Sex-Specific Independent living

Independent living can occur in either an individual or group home setting. These programs are required to provide sex-specific treatment similar to a Level Two modalities, goals and frequency (listed above on pages 20-21) with additional independent living skills development opportunities and interventions.

Treatment Providers:

Those individuals providing targeted sex-specific therapy interventions (whether it is individual, family or group therapy), should be certified by NOJOS as a Sex-Specific provider. Individuals providing trauma-specific treatment (whether it is individual or group therapy), should be licensed mental-health clinicians with some experience and training in working with youth who have been traumatized. Sex-Specific treatment providers should have training in understanding adolescent development and trauma, as well as neurophysiology and etiological (including maintenance factors) impact on developmental trajectory. They also need to be aware of the influence of family, environment, social and culture on the youth.

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Those individuals providing skills-development services or other skills-based groups (i.e. anger/aggression, mood management, prosocial skills, etc.) must be trained and competent to provide the service; however, although they are not required to have a clinical license or be certified by NOJOS, it is recommended that they have attended and completed the NOJOS Basic Line Staff Training. Regardless, providers of these adjunct services should work under the supervision of a NOJOS Certified Sex-Specific Clinician.

Monitoring:

The majority of Level Five youth are in Department of Human Services' custody with either DCFS or DJJS. The Division case manager, along with the NOJOS Certified Sex-Specific Clinician and group home staff, work together to monitor the youth's compliance in the group home, school setting and in their sex-specific therapy. Additionally, in some cases, Level Five youth receive additional tracking services to increase monitoring and social support. If/when the youth's family is actively involved in the youth's care, and especially when the youth is to be eventually reunified with their family of origin, the parent(s)/guardian(s) must be involved in the treatment process. The parent(s)/guardian(s) may also provide supervision for the youth as deemed appropriate and approved by the NOJOS Certified Clinician and Division case manager once the family is educated on the youth's risk and supervision needs and a family safety and supervision guideline plan has been developed.

Criteria for Discharge:

In Level Five, different resources usually provide treatment and placement services. Networking and case coordination are essential to track the youth's treatment progress. There should be a consensus between the placement and treatment teams that the goals for treatment are being met. Specifically, at discharge a consensus should exist between treatment and placement services providers. Placement programs should also work to ensure no conflicts exist in treatment philosophy. If this occurs, programs should always error on the side of caution and follow currently-accepted national assessment and treatment standards and NOJOS protocols. It is recommended that all youth have one primary NOJOS Certified Sex-Specific Clinician to direct and oversee treatment to avoid such conflict.

Transfer to an outpatient-treatment program (Level Two or Level Three) is appropriate when the youth has progressed sufficiently in a Level Five treatment program. This once again supports the step-up step-down model. The length of treatment in the step-up step-down model may be approximately eighteen to twenty-four months. Lack of treatment progress may result in referral to more intensive treatment and/or supervision, and may also result in increased length of treatment.

Criteria for treatment progress include: "Accomplishment of the specific treatment goals and objectives, cooperativeness in treatment, maintaining control and self-responsibility, changes in thinking, and observable changes of behavior over time" (National Task Force on Juvenile Sexual Offending, 1993, p. 52).

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Level Five Sex-Specific Group Home treatment has an indeterminate length, as it is partially dictated by the calendar school year and the varying progress and needs of the youth. As deemed appropriate, once a youth successfully completes Level Five Sex-Specific Group Home treatment, a step-down to Level Two sex-specific outpatient treatment or a referral to traditional mental-health services may be appropriate. In the case that the youth is unable to return to their family environment, a step-down to a Level Four may be appropriate. As in any treatment level, lack of treatment progress may result in a referral to a more-intensive treatment intervention. However, as stated above, all changes in placement or clinical level should be based on increased or decreased risk as measured by nationally accepted risk assessment tools rather than *solely* on resistance and/or noncompliance.

It is recommended that Level Five youth undergo a discharge assessment to determine if:

1. Family issues and environmental risk factors have been stabilized and/or reduced;
2. A stable support system has been developed;
3. Co-morbid issues have been addressed/stabilized;
4. Risk has been lowered;
5. Level of functioning/skills have improved;
6. Etiological and maintenance factors, as well as treatment issues identified in the intake assessment, have been addressed;
7. Protective factors and resiliency, as well as internal and external assets, have been increased, and progress has occurred on sex-specific treatment goals.

The progress indicators established by the National Task Force on Juvenile Sexual Offending are also useful to evaluate treatment progress (The Revised Report from the National Task Force on Juvenile Sexual Offending, 1993 of The National Adolescent Perpetrator Network, *Juvenile and Family Court Journal*, 1993, Vol. 44, No. 4, page 52) (See summary on page 22 above).

As detailed in the NOJOS Assessment Protocol, an updated sex-specific assessment is recommended prior to any discharge or step-up or step-down in the NOJOS continuum.

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Level Six:
Sex-Specific Residential Intensive /
Sex-Specific Treatment

Client Profile:

Level Six programs serve higher-risk youth who engage in sexual misconduct with a broad range of sexual-offense behaviors and who are often sexually-preoccupied. These youth have serious and significant sexual acting out issues, potentially highlighted by being patterned and repetitious behaviors. They may have persistent or fixated patterns of offending, use of force or weapons in committing their offenses and/or a display a propensity to act out with same-aged peers in addition to their younger victims. These are youth with multiple vulnerabilities and deficits in their ability to meet their needs and obtain human goods (i.e., healthy living, knowledge, excellence in play and work, excellence in self agency, freedom from emotional turmoil and stress, friendship, community, purpose in life, happiness and creativity). Treatment for these youth must go beyond the sexual problems and must focus on treating the entire person. Specifically, these youth have multiple deficits and vulnerabilities in several categories—these issues make up the youth's etiological and maintenance factors:

1. Developmental issues—these youth have significant development issues as evidenced by:
   - Failure or disruptions in the developmental stages;
   - Attachment deficits;
   - Learning disabilities;
   - Intimacy deficits;
   - Verbal expression deficits;
   - Co-morbidity of mental health issues;
   - Cognitive distortions.

2. Environmental issues—youth who come from difficult, unhealthy or negative environments as marked by:
   - Negative family environment;
   - Family instability, disorganization and violence;
   - Poor child-rearing practices;
   - Familial rejection, abuse and neglect;
   - Lack of interaction between parents and child;
   - Parental conflicts and disagreements;
   - Parental or familial separations ;
   - Socio-economic difficulties ;
   - Parental criminality;
   - Parental substance-abuse issues;

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- Parental mental-health issues;
- Negative peer influence.

3. Deficits in executive functioning—these youth have significant deficits in executive functioning resulting in problems with self regulation as evidenced by:
    - Emotional self-regulation problems;
    - General self-regulation problems;
    - Limited rules for appropriate social behavior and interaction;
    - Poorly-developed or primitive senses of morality;
    - Poorly-defined sense of personal boundaries and taboos;
    - Failure to understand consequences of their behavior;
    - Limited self control over
        - ~ ADHD
        - ~ Anger management
        - ~ Impulsivity;
    - Can be Conduct Disordered or Oppositional Defiant Disordered;
    - Difficulty in goal-directed actions;
    - Difficulty in monitoring, evaluation, selection and modification of behavior;
    - Ineffective strategies and coping skills.

4. Cognitive distortions—their cognition is distorted, which has led to distorted beliefs and values and an underdeveloped and inadequate morality.

5. Emotional issues—these youth also experience significant problems in emotional identification, expression and regulation including:
    - Depression and anger issues;
    - Difficulty identifying, understanding and expressing emotions;
    - Limited emotional expression;
    - Inability to control intensity of emotion;
    - Inability to match correct emotion with the context and/or circumstances;
    - Inability to recognize internal and external emotional cues and non-verbal language;
    - Act out their emotional experiences through negative or otherwise inappropriate behaviors.

6. Self-concept deficits—these youth present with problems and deficits in their self concept and worth which includes:
    - Deficits in self-esteem, worth, independence and confidence;
    - Misattributions or perceptions of self;
    - Deficits in autonomy and assertiveness;
    - Deficits in self-satisfaction;
    - Unsolidified self identity.

7. Social competency and social relatedness deficits—deficits in social competency and social relatedness result in a lack of skills necessary to master their environments and succeed in social relationship and intimate connections.

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8. Childhood maltreatment—they have experienced significant childhood maltreatment and trauma including:
   - Neglect and lack of appropriate attachment and bonding;
   - Sexual, physical and psychological abuse;
   - Exposure to domestic violence;
   - Bullied, ridiculed and teased;
   - Isolated and rejected.

9. Awareness deficits—they possess awareness deficits highlighted by:
   - Lack of empathy;
   - Lack of concern for others;
   - Little remorse for behaviors;
   - Little insight into the needs and feelings of others;
   - Place own needs and feelings ahead of needs and feelings of others;
   - Narcissistic qualities.

In addition, these youth often have additional co-morbid mental-health issues and learning disabilities, and many also have a prior treatment history.

Level Six youth present a significant risk for reoffending sexually, and thus, require intervention in a structured and restrictive residential treatment setting. These youth possess multiple risk, etiological and maintenance factors—it is these factors that place all youth on the pathway to sexually offend. However, Level Six youth have *more factors expressed at a higher level of intensity*. Due to the manner in which these youth sexually offend and the number and variety of etiological and maintenance factors identified in these youth, they score in the ***moderate-to-high and high risk*** range on acceptable national risk assessment tools. They possess risk too great to remain in the community or be placed with less-sophisticated youth in Level Five settings. They are youth in need of intensive structure, treatment and supervision in order to address their sexual-acting out issues and other vulnerabilities, deficits and treatment needs. These youth usually require more-intensive intervention than provided in less-intensive programming. According to Burton et al. (in press 2007), these youth also lack empathy, may be extremely opportunistic and aggressive toward others and may show predatory patterns. Many exhibit severe psychiatric problems but are not usually thought-disordered or dissociative (thought-disordered youth are more appropriate for Level Seven).

Those factors that DIFFER from a Level Five youth include:

1. Present as more developmentally mature than a Level Five;
2. Present with an unwillingness to alter or "give up" inappropriate sexual interests/attitudes;
3. Present with entrenched difficult temperamental traits, denial and defensive personality structure;
4. Have demonstrated a high level of manipulation, sophistication and/or impulsivity;
5. Display more aggressive, conduct disordered or antisocial attitudes/behaviors;
6. Evidence persistence in sexual behavior and premeditation;
7. Present as less amenable or receptive to treatment than a Level Five youth;

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8. Have received prior outpatient treatment;
9. Have reoffended sexually;
10. Have displayed lapse(s) in judgment or sexual behaviors (i.e. increased masturbation or pornography use, excessive interest in, and association with, children, etc.) while in a lower Level of care;
11. Exhibit negative or unhealthy psychosocial stressors with peers;
12. Present with highly-manipulative, predatory or fixated patterns of offending;
13. Have a propensity to sexually act out with same-aged peers in addition to their younger victims;
14. Demonstrate sexual preoccupation, obsession and/or deviant sexual interests;
15. Display an acute psychiatric disturbance (chronic psychiatric disturbances are more appropriate for Level Seven);
16. Demonstrate psychopathic or antisocial tendencies;
17. Have higher frequency and duration of offending (typically greater than six months);
18. Have multiple and indiscriminate victims;
19. Have a high degree of intrusive and diverse sexual-offending behaviors;
20. Used force/intimidation in offending;
21. Present with co-existing behavioral/emotional problems (dual diagnosis);
22. Display other criminal behavior or antisocial thinking;
23. Progression from less-intrusive to more-intrusive offense behaviors;
24. Have received prior adult sanctions for sexual misconduct;
25. History of interpersonal aggression;
26. Poor self-regulation;
27. Greater propensity to abscond from a less-restrictive setting;
28. Present a significant risk to the community.

These youth may have also failed in a lower NOJOS Level program or present a risk to the community that requires higher-intensity supervision and treatment. Adjudication of these youth is mandatory.

Treatment:

A Level Six program is a twenty-four-hour intensive community-based residential treatment program. It provides maximum, non-secure supervision and intensive clinical intervention. It is not a locked facility but is staff secure. Level Six Residential treatment differs from lower levels of treatment, in that Level Six Residential treatment is more clinically-intensive and treatment services occur more frequently. Treatment includes empirically-validated sex-specific models and techniques that are nationally accepted and regularly updated (i.e., cognitive-behavioral, risk/needs and strength-based rehabilitation treatment).

As noted earlier, NOJOS' Level Six treatment philosophy, consistent with national literature, endorses the use of a holistic/integrated approach to treating youth who engage in sexual misconduct. This approach blends traditional aspects of sex-specific treatment into a more holistic and developmentally-consistent model for working with youth. Treatment not only focuses on the sexual problems, but also addresses the youth's growth and development, health, social skills, resilience and interventions focused on resolving the youth's own victimization and

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co-occurring disorders. The primary aim is to instill in the youth the knowledge, skills and competencies necessary to develop and implement a positive identity revolving around personally-meaningful ways of meeting their human needs and pursuing their interests. As part of this holistic approach, treatment should integrate standard sex-offense-specific treatment components, such as development of full accountability for all offense behaviors, insight into offense dynamics and choice to offend, building realistic and effective self regulation/relapse-prevention strategies, develop a family safety plan, develop healthy sexual attitudes and boundaries and develop and sustain victim empathy.

Treatment should include sex education and healthy sexuality work, life-skills training, skills-development training, independent-living skills and psychiatric/medication management services. A psychosexual-education emphasis is also recommended to provide the youth with information regarding maturation, human development, healthy sexual functioning and the current laws regarding sexual conduct.

Additionally, trauma-specific treatment interventions should also be utilized with those youth who present with an unresolved trauma history. It is strongly recommended the youth have opportunities to resolve his/her own childhood victimization with sensory interventions, *separate from* focus on his/her sexual offending to assist him/her to resolve his/her trauma, enhance his/her emotional coping skills and develop a healthy sexual identity.

Treatment Goals:

Level Six treatment must include targeted sex-specific therapy to include individual therapy, group therapy and family therapy weekly to provide the youth with information regarding healthy sexual functioning and prevent further development of his/her sexual misconduct. Level Six programs should also be capable of providing offense-specific risk and clinical evaluation. Treatment services include sex-specific treatment, psycho-social education and training groups in daily living and social skills, healthy sexuality and psychosexual education, family therapy, individual therapy, group therapy, psychological evaluation and testing, psychiatric evaluation and, as deemed appropriate, medication management.

Specific treatment goals for this level are those identified by the National Task Force on Juvenile Sexual Offending (1993). These goals include increases in the offender's adaptive levels of functioning behaviorally, emotionally, socially, cognitively and psychologically. In addition to these goals, the youth should improve their executive functioning, social competency and relatedness, use of social skills in demonstrating mastery in their environment and stabilization of behavior in social, school and home setting.

Overall, the goal is to assist the youth to increase competency and skills necessary to ensure their ability to control or eliminate etiological and maintenance factors influencing their pathway to offend, reestablish a healthy developmental trajectory (in all developmental stages), obtain their needs and human goods in a healthy way, and place themselves back on a healthy pathway towards becoming a functional, healthy and happy adult (Ward, T.; Polaschek, D. and Beech, A. Theories of Sexual Offending, John Wiley & Sons, Ltd. 2006).

A full list of Sex-Specific Treatment Goals is presented above on pages 12 - 13.

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Treatment Modalities:

Level Six programs are staff-secure, community-based facilities either freestanding, or a more controlled unit, within an overall residential campus where resident activities and movements are controlled or monitored by staff on a twenty-four-hour basis, and there is a strong emphasis on structure, intensive behavior management and containment. These facilities typically provide on-site schooling, as well as frequent and intensive psychological or psychiatric services delivered by on-site professional staff. These facilities rely upon behavioral systems or level systems to gain compliance from residents. (See also *Current Perspectives: Working with Young People Who Sexually Abuse,* Current Perspectives: Working with Sexually Aggressive Youth & Youth With Sexual Behavior Problems, Longo, Robert E. & Prescott, David S., Editors, NEARI Press, 2006, page 52-53.)

For youth who require placement in a Level Six, intervention to decrease sexually-abusive behavior problems is an integral part of an overall structured program. Individual, family, group and recreational therapies, as well as the therapeutic milieu intervention, provide the basic structure. Additionally, the youth participate in group therapy that focuses on sex-offending issues. Level Six youth typically cannot be adequately treated in a non-sex-specific or traditional residential program where the client population is insufficient to create a homogeneous group for youth with sexually-abusive behavior problems.

The treatment of youth who engage in sexual misconduct requires specialized training and a unique treatment approach. At a minimum, Level Six treatment should include the following treatment modalities and components:

1. Sex-specific group therapy two to three times per week focused on allowing the youth to work on accomplishing the treatment goals and expectations of sex-specific treatment with the support of a peer group;

2. Cycle work focusing on the identification and understanding of contributing factors (thought, feelings and behaviors) that occur before, during and after a youth's sexual misconduct, and development of coping strategies specific to each factor to interrupt unhealthy cycles and establish a relapse-prevention/self-regulation plan for such factors;

3. Sexual-arousal modification, including use of strategies to help the youth understand their sexual attractions and arousals, differentiate healthy from unhealthy sexual functioning and develop the self-regulation and coping skills to control deviant impulses;

4. Sex education and healthy sexuality development in individual therapy, and/or a psychosexual educational group setting, to teach the youth about human sexuality and enhance their understanding of developmentally expected, healthy, appropriate adolescent sexual unfolding and expression. NOJOS Certified Sex-Specific Clinicians should use a psychosexual education curriculum that specifically addresses the unique characteristics of youth who engage in sexual misconduct (See NOJOS Level One above);

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5. Life-skills training in a group setting centered on the mastery of life and social skills. This group encompasses both social skills specific to this population and traditional independent-living skills;

6. Individual therapy one to two times weekly addressing both sex-specific and more general psychological issues and needs;

7. Family therapy weekly (as determined appropriate by clinician). Family therapy should focus on family dynamics associated with the youth's misconduct and/or problematic functioning, as well as supervision, safety and assisting the youth to manage his/her risk. Family therapy should also include education of the parents/caregivers regarding the youth's current risk factors, treatment goals and supervision needs;

8. Highly-structured academic programming (i.e., certified accredited self-contained classroom, sex-specific day treatment programming or youth-in custody educational programming);

9. Psychiatric and medication management.

Treatment Providers:

Those individuals providing targeted sex-specific therapy interventions, whether it is individual, family or group therapy, should be certified by NOJOS as a Sex-Specific provider. Individuals providing trauma-specific treatment, whether it is individual or group therapy, should be licensed mental-health clinicians with some experience and training in working with youth who have been traumatized. Sex-Specific treatment providers should have training in understanding adolescent development and trauma, as well as neurophysiology and etiological (including maintenance factors) impact on developmental trajectory. They also need to be aware of the influence of family, environment social and culture on the youth.

Those individuals providing skills-development services or other skills based groups (i.e. anger/aggression, mood management, prosocial skills, etc.) must be trained and competent to provide the service; however, although they are not required to have a clinical license or be certified by NOJOS, it is recommended that they have attended and completed the NOJOS Basic Line Staff Training. Regardless, providers of these adjunct services should work under the supervision of a NOJOS Certified Sex-Specific Clinician.

Monitoring:

Level Six community-based placement provides maximum, non-secure supervision and intensive sex-specific clinical intervention. Youth in sex-specific residential placements are typically in the custody of the DCFS or DJJS. The juvenile justice authority, NOJOS Certified Sex-Specific Clinician and Level Six agency act as an intervention team to ensure the youth's compliance and progression in the treatment program.

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Level Six programs must be staffed at a ratio of one staff to three clients at all times with the exception of nighttime sleeping hours when staff may be reduced. However, at least two awake direct-care staff, or a ratio of one staff to five clients, must be on duty during nighttime sleeping hours. Level Six programs are required to provide twenty-four-hour wake supervision. The youth must be in line-of-sight supervision during all wake hours (excluding privacy time). Youth must be checked at least every fifteen minutes during nighttime supervision.

In a long-term sex-specific residential treatment program, youth are monitored therapeutically and by residential staff. If home visits are approved, parents are expected to report to staff following each visit.

Adjudicated youth are additionally monitored by the Juvenile Court and the Division of Juvenile Justice Services for compliance to treatment. When DCFS maintains custody or protective supervision of the youth, the DCFS caseworker also monitors compliance.

Criteria for Discharge:

Youth admitted to residential-intensive treatment have significant abusive-behavior patterns that require long-term treatment intervention. Length of stay in a Level Six treatment program averages eighteen to twenty-four months, with six to twelve months of follow-up aftercare services. However, some youth may stabilized more quickly, and based on progress and current assessment, step-down to a less restrictive Level of care. Aftercare following Level Six placement may take place in an outpatient-treatment program with treatment goals and modalities similar to those given to Level Two youth, but specifically focused on assisting the youth to address issues related to their reintegration into the community. In this situation, Level Two provides a less-restrictive environment for transition and practice of skills learned in the Level Six intensive-residential program.

Criteria for treatment progress include: "Accomplishment of the specific treatment goals and objectives, cooperativeness in treatment, maintaining control and self-responsibility, changes in thinking, and observable changes of behavior over time" (National Task Force on Juvenile Sexual Offending, 1993, p. 52). As in any treatment level, lack of treatment progress may result in a referral to a more-intensive treatment intervention or Level of care—in this case, incarceration in a Level Eight secure-care facility. However, as stated above, all changes in placement or clinical level should be based on increased or decreased risk as measured by nationally-accepted risk assessment tools rather than *solely* on resistance and/or noncompliance.

It is recommended that Level Six youth undergo a discharge assessment to determine if:

1. Family issues and environmental risk factors have been stabilized and/or reduced;
2. A stable support system has been developed;
3. Co-morbid issues have been addressed/stabilized;
4. Risk has been lowered;
5. Level of functioning/skills has improved;
6. Etiological and maintenance factors, as well as treatment issues identified in the intake assessment, have been addressed;
7. Protective factors, resiliency, internal and external assets have been increased;

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8. Progress has occurred on sex-specific treatment goals.

The progress indicators established by the National Task Force on Juvenile Sexual Offending are also useful to evaluate treatment progress (The Revised Report from the National Task Force on Juvenile Sexual Offending, 1993 of The National Adolescent Perpetrator Network, *Juvenile and Family Court Journal*, 1993, Vol. 44, No. 4, page 52) (See summary on page 22 above).

As detailed in the NOJOS Assessment Protocol, an updated sex-specific assessment is recommended prior to any discharge or step-up or step-down in the NOJOS continuum.

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Level Seven:
Inpatient Psychiatric / Sex-Specific Treatment

Client Profile:

Youth appropriate for Level Seven present with an acute or chronic psychiatric disturbance, are sexually impulsive, display unpredictable/uncharacteristic or pattern of bizarre/ritualistic offenses, unpredictable social behaviors and present a ***high risk*** to the community and/or the safety of other youth in lower level programming. Adjudication of these youth is mandatory.

These youth differ from Level Six and Level Eight youth based on their psychiatric disturbance. Their placement in Level Seven care is facilitated by their inability to manage their mental illness and are therefore in need of Level Seven placement to stabilize their psychiatric disturbance.

Treatment Goals:

It is important to note that the primary focus of Level Seven programming is stabilization of the mental illness, and not necessarily treatment for the sexually-abusive behaviors. Ideally, the sex-specific treatment should occur in a lower level of treatment subsequent to the youth's stabilization. Nevertheless, sex-specific treatment should be initiated at this level of care, in conjunction with traditional mental-health counseling, until the youth has stabilized psychiatrically. Once transitioned to a lower level of care, the youth's sex-specific therapy should then be the primary focus in treatment. Treatment must also focus on management of problem behaviors (e.g., aggressiveness, impulsiveness or compulsive patterns of sexually-assaultive behavior).

Specific treatment goals for this level are those identified by the National Task Force on Juvenile Sexual Offending (1993). These goals include increases in the offender's adaptive levels of functioning behaviorally, emotionally, socially, cognitively and psychologically.

Stabilization of psychiatric condition was defined by Ryan and Lane (1997): The goals of interventions to address concurrent psychiatric disorders are: 1) to manage the effects that might impeded success in the offense program; 2) to achieve resolution of or develop a life span management perspective of effects that might impeded success in relationships; 3) to achieve optimal global functioning; and 4) to achieve understanding and acceptance of those disorders that are unchangeable (Ryan, G. and Lane, S., Juvenile Sexual Offending: Causes, Consequence, and Correction, Jossey-Bass Press, 1997, page 315).

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Treatment Modalities and Frequencies:

Level Seven programs are a locked, controlled-access units, either freestanding or a more-controlled unit within an overall residential psychiatric campus, where the youth's activities and movements are controlled or monitored by staff on a twenty-four-hour basis, and there is a strong emphasis on structure, intensive behavior management and containment. Level Seven facilities provide on-site schooling as well as frequent and intensive psychological and/or psychiatric services delivered by on-site professional staff. These facilities often have seclusion and restraint capacity and rely upon behavioral systems or level systems to gain compliance from residents (*Current Perspectives: Working with Young People Who Sexually Abuse,* Current Perspectives: Working with Sexually Aggressive Youth & Youth With Sexual Behavior Problems, Longo, Robert E. & Prescott, David S., Editors, NEARI Press, 2006, page 52-53).

Level Seven sex-specific interventions are integrated into a more general psychiatric structured program. Therefore, traditional mental-health services are required, including individual, family and group therapy, as well as psychiatric and medication-management services. Therapy interventions are designed to address more general psychiatric issues and provide a solid foundation for understanding and addressing related sexual issues/problems. However, the youth should participate in regular sex-specific individual and group therapy that focuses on sex-specific issues. Further, unlike Level Six youth, if the client population is insufficient to create a group for the youth with sexually-abusive behavior problems, the clinician may address the youth's inappropriate sexual behaviors within individual/family therapy. Otherwise, sex-specific treatment modalities should be similar to Level Six treatment modalities (See pages 36-37). The clinician who provides the therapy must be a NOJOS Certified Sex-Specific Clinician.

Given that the primary focus of Level Seven treatment is to assess and treat the acute or chronic psychiatric issues, once the youth's psychiatric disturbance is controlled/stabilized, the youth should be placed in a lower Level of treatment.

Treatment Providers:

Treatment providers should have expertise and experience in working with adolescents with acute and/or chronic psychiatric problems/issues. They should also have training and experience in understanding how psychiatric issues interplay with adolescent sexual development. Those individuals providing targeted sex-specific therapy interventions (whether it is individual, family or group therapy), should be certified by NOJOS as a Sex-Specific provider. Individuals providing trauma-specific treatment (whether it is individual or group therapy), should be licensed mental-health clinicians with some experience and training in working with youth who have been traumatized. Sex-Specific treatment providers should have training in understanding adolescent development and trauma, as well as neurophysiology and etiological (including maintenance factors) impact on developmental trajectory. Additionally, they need to be aware of the influence of family, environment, social and culture on the youth.

Those individuals providing skills development services or other skills based groups (i.e. anger/aggression, mood management, prosocial skills, etc.) must be trained and competent to provide the service; however, although they are not required to have a clinical license or be

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certified by NOJOS, it is recommended that they have attended and completed the NOJOS Basic Line Staff Training. Regardless, providers of these adjunct services should work under the supervision of a NOJOS Certified Sex-Specific Clinician.

Monitoring:

In a NOJOS Level Seven treatment program, youth are monitored therapeutically and by residential staff. If home visits are approved, parents/guardians are expected to report to staff following each visit. Adjudicated youth are additionally monitored by the Juvenile Court and DJJS to ensure compliance with treatment. When DCFS maintains custody or protective supervision of the youth, the DCFS caseworker also monitors compliance.

Criteria for Discharge:

The youth may be successfully discharged from the Level Seven program and transitioned to a lower level of care when the youth demonstrates:

1. Stabilization of the mental illness;
2. They are no longer a danger to self or others;
3. They do not present with active psychosis or thought disorder symptoms;
4. Improved problem-solving and emotional-regulation skills.

The NOJOS Certified Sex-Specific Clinician(s) and the juvenile justice monitoring team evaluate the youth's treatment progress, assess risk and determine an appropriate aftercare placement. Clinicians can use the progress indicators established by the National Task Force on Juvenile Sexual Offending (1993) to evaluate treatment progress and assess risk (The Revised Report from the National Task Force on Juvenile Sexual Offending, 1993 of The National Adolescent Perpetrator Network, *Juvenile and Family Court Journal*, 1993, Vol. 44, No. 4, page 52) (See summary on page 22 above).

Additionally, the parent(s)/guardian(s) must demonstrate understanding of the youth's sexually abusive behavior problems and an ability and willingness to supervise. Transfer to a lower level of clinical intervention (e.g., sex-specific residential intensive, sex-specific group home, proctor/foster care, day treatment or outpatient) is usually necessary to maintain changes achieved by inpatient hospitalization. Aftercare should provide the youth and family support.

If the youth has been adjudicated, or is receiving supervision from the Juvenile Court, the Juvenile Court personnel should be involved in placement decisions. Similarly, if the youth has been placed in the custody or protective supervision of the DJJS or DCFS, the Division case manager should be involved in placement decisions. Treatment professionals in both Level Seven and aftercare settings should be careful to coordinate the transfer of treatment services and keep parent(s)/guardian(s) adequately informed of all discharge plans.

It is required that Level Seven youth undergo a discharge assessment to determine if:

1. Mental illness has been stabilized;

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2. Risk has been lowered;
3. They are no longer a danger to self or others;
4. Level of functioning has improved;
5. A stable support system has been developed;
6. Treatment issues identified in the intake assessment have been addressed;
7. Progress has occurred on sex-specific treatment goals.

As detailed in the NOJOS Assessment Protocol, an updated sex-specific assessment is recommended prior to any discharge or step-up or step-down in the NOJOS continuum.

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PROTOCOLS AND STANDARDS
FOR YOUTH WHO ENGAGE IN SEXUAL MISCONDUCT

Level Eight: Secure Care / Correctional Treatment Enhanced

Client Profile:

Level Eight youth have displayed repetitious, predatory, fixated and/or violent patterns of offending, use of force or weapons in their offenses and/or a propensity to sexually act out with same-aged peers in addition to younger victims. Level Eight youth may also display other criminality or non-sexual aggression that makes them too risky to maintain in a community placement. These youth also present with antisocial-interpersonal orientation or conduct-disorder behaviors that render them unable or unwilling to follow the structure and rules of community-based programs. These youth usually have a prior treatment history and have often failed previous placements and less-restrictive treatment options. Secure Care youth present an extreme risk to the community. Primary factors to consider are the higher frequency and degree of severity of the behaviors and/or the extended length of time the youth has exhibited these behaviors.

These youth differ from Level Six youth based on:
- Use of aggression in the offending;
- Violent patterns or use of force or weapons during the course of their offense;
- Overall criminality and non-sexual delinquency makes it difficult to maintain the youth in a community program;
- Aggression, acting out and/or AWOL risk cannot be maintained in a community-based program;
- Defined development of antisocial traits that make it difficult to treat the youth in the community;
- Failure in lower-level treatment programs.

Treatment:

Secure facilities are the final NOJOS Level, and most secure confined settings, for youth who commit repetitive sexual and/or nonsexual-assault behaviors. Secure facilities are long-term, locked confinement facilities for serious and habitually-delinquent youths. They are similar to adult prisons. Secure facilities have high security and multiple barriers preventing escape. These facilities provide some professional psychological or psychiatric treatment services and may use a level system. Participation in school or GED services is required for these youth. Behavioral change is often pursued via control and application of sanctions.

Delinquent youth are not sentenced for a specific length of time, but their stay is based on the guidelines established by the Youth Parole Authority. The Youth Parole Authority conducts regular progress reviews and determines when the youth can be released. Once the Juvenile

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Court orders a delinquent youth to a secure facility, the authority for the youth is transferred to the Youth Parole Authority. Unlike the adult-correctional system, juveniles placed in secure facilities must receive educational and vocational services. Each juvenile must complete an individually-designed treatment plan based on their rehabilitative needs, and they must complete the court-ordered victim restitution as part of the requirements for release. YIC teachers, who are employed by the school districts, hold daily classes for youth. Schoolwork finished in secure facilities is credited to the youth's regular academic record (http://www.jjs.utah.gov/secure-facilities.html).

In locked, correctional settings, treatment is often considered a privilege, even though in many ways these youth present the greatest need for treatment intervention in order to return to a normative path of development and rehabilitate. National literature indicates youth refusing to meaningfully participate in treatment over reasonably-appropriate periods of time should be discharged from treatment groups and not be provided with additional benefits or perquisites. They should also be required to serve the maximum sentence imposed by a judge. However, the option of participating in treatment should be available to these youth at any time during their incarceration (David S. Prescott and Robert E. Longo, *Current Perspectives: Working with Young People Who Sexually Abuse,* Current Perspectives: Working with Sexually Aggressive Youth & Youth With Sexual Behavior Problems, Longo, Robert E. & Prescott, David S., Editors, NEARI Press, 2006, page 53-54).

Treatment Goals:

The treatment goals for this level are those identified by the National Task Force on Juvenile Sexual Offending (1993). These goals include increases in the youth's adaptive levels of functioning behaviorally, emotionally, socially, cognitively and psychologically. In addition to these goals, the youth should improve their executive functioning, social competency and relatedness, use of social skills in demonstrating mastery in their environment, as well as stabilization of behavior in social, school and home setting.

Overall, the goal is to assist the youth to increase competency and skills necessary to ensure their ability to control or eliminate etiological and maintenance factors influencing their pathway to offend, reestablish a healthy developmental trajectory (in all developmental stages), obtain their needs and human goods in a healthy way and place themselves back on a healthy pathway towards becoming a functional, healthy and happy adult (Ward, T.; Polaschek, D. and Beech, A. Theories of Sexual Offending, John Wiley & Sons, Ltd. 2006).

A full list of Sex-Specific Treatment Goals is presented above on pages 12 - 13.

Treatment Modalities:

Secure facilities provide correctional programming enhanced with sex-specific and trauma-specific treatment modalities similar to a Level Six program. Secure care treatment focuses on the following:

- Sex Abuse prevention;

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- Community protection;
- Rehabilitation;
- Development of a healthy non-offending self-identity.

Secure treatment modalities include targeted sex-specific therapy to include individual therapy and group therapy weekly to provide the youth with information regarding healthy sexual functioning and prevent further development of his/her sexual deviancy. If reunification is the goal, and/or family issues are a significant part of the youth's problems, family therapy should also be provided if possible. With older adolescents, individuation issues should be addressed to assist the youth to move toward young adulthood and emancipation.

Treatment should include sex education and healthy-sexuality work, life-skills training, skills-development training, independent-living skills and psychiatric/medication management services. A psychosexual-education emphasis is recommended to provide the youth with information regarding maturation, human development and the current laws regarding sexual conduct.

Trauma-specific treatment should also be available for those youth who present with an unresolved trauma history. It is strongly recommended the youth have opportunities to resolve his/her own childhood victimization with sensory interventions *separate from* focus on his/her sexual offending to assist him/her to resolve his/her trauma, enhance his/her emotional coping skills and develop a healthy sexual identity.

Treatment Providers:

Those individuals providing Level Eight targeted sex-specific services, whether it is individual, family, or group therapy, must be certified by NOJOS as a Sex-Specific Clinician. Individuals providing trauma-specific treatment, whether it is individual/group therapy, should be licensed mental health clinicians with some experience and training in working with youth who have been traumatized. Sex-Specific treatment providers should also have training in understanding adolescent development, trauma and neurophysiology and etiological and maintenance factors impact on developmental trajectory. Additionally, they need to be aware of the influence of family, environment, social and culture, on the youth.

Those individuals providing skills-development services or other skills-based groups (i.e. anger/aggression, mood management, prosocial skills, etc.) must be trained and competent to provide the service; however, although they are not required to have a clinical license or be certified by NOJOS, it is recommended that they have attended and completed the NOJOS Basic Line Staff Training. Regardless, providers of these adjunct services should work under the supervision of a NOJOS Certified Sex-Specific Clinician.

Monitoring:

Secure confinement provides maximum supervision of the most dangerous sexually-abusive youth and intensive sex-specific clinical intervention. The Juvenile Court places custody of the juvenile with the Youth Parole Authority. The Youth Parole Authority (through DJJS), the

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NOJOS Certified Sex-Specific Clinician(s) and the correctional facility's clinical team monitor the youth's compliance and progress in the treatment program.

Criteria for Discharge:

Length of stay in a secure facility typically ranges from eighteen to twenty-four months. The clinical intervention team and the Juvenile Justice case manager monitor treatment progress and determine when the youth is eligible for release to a less-restrictive level of care. The Youth Parole Authority must approve release. Depending on risk potential, the youth may then transfer to residential-intensive (Level Six), sex-specific group home (Level Five), proctor care (Level Four) or outpatient treatment (Level Two). The combined length of treatment in secure confinement and aftercare settings ranges from eighteen to thirty months. If the youth fails to respond to treatment in secure confinement, certification into the adult system may also be an option.

Criteria for treatment progress include: "Accomplishment of the specific treatment goals and objectives, cooperativeness in treatment, maintaining control and self-responsibility, changes in thinking, and observable changes of behavior over time" (National Task Force on Juvenile Sexual Offending, 1993, p. 52). The progress indicators established by the National Task Force on Juvenile Sexual Offending are also useful to evaluate treatment progress (The Revised Report from the National Task Force on Juvenile Sexual Offending, 1993 of The National Adolescent Perpetrator Network, *Juvenile and Family Court Journal*, 1993, Vol. 44, No. 4, page 52) (See summary on page 19 above). Lack of treatment progress may result in extended duration of confinement or more-restrictive parole considerations.

According to Utah Code Annotated, Section 77-27-21.5 (1) (vi), any juvenile who has been adjudicated delinquent, based on one or more felony or class A misdemeanor sex offense(s) and who has been committed to the Division of Juvenile Justice Services for secure confinement and remains in the division's custody thirty days prior to the person's twenty-first birthday, is required to register as a sex offender with the department by the division prior to release from confinement (Amended by Chapter 269, 2006 General Session; Amended by Chapter 334, 2006 General Session; Amended by Chapter 189, 2006 General Session).

It is required that Level Eight youth undergo a discharge assessment to determine if:

1. Risk has been lowered;
2. Co-morbid issues have been addressed/stabilized;
3. Level of functioning has improved;
4. A stable support system has been developed;
5. Treatment issues identified in the intake assessment have been addressed;
6. Progress has occurred on sex-specific and non-sex-specific treatment goals.

As detailed in the NOJOS Assessment Protocol, an updated sex-specific assessment is recommended prior to any discharge or step-up or step-down in the NOJOS continuum.

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References

Barbaree, H. and Marshall, W., Editors, The Juvenile Sex Offender, Second Edition, The Guilford Press, 2006

Burton, J., Rasmussen, L. A., Christopherson, B. J., Bradshaw, J., & Huke, S. C. (In Press). Interrupting sexually abusive behavior problems: A clinician's guide for child and parent treatment. Manuscript under contract for publication. Newbury Park, CA: Sage Publications.

Coffey, Patricia, Ph.D., *Forensic Issues In Evaluating Juvenile Sex Offenders*, Risk Assessment of Youth Who Have Sexually Abused, Prescott, David S., LICSW, Wood & Barnes Publishing, 2006, page 80-81.

Creeden, K., *Integrating trauma and attachment research into the treatment of sexually abusive youth*. In M.C. Calder (Ed.), Children and Young People Who Sexually Abuse: New Theory, Research, and Practice Developments. Lyme Regis, Dorset: Russell House Publishing, 2004.

Creeden, K., *Trauma, attachment and neurodevelopment: Implications for treating sexual behavior problems*. In B. Schwartz (Ed.), The Sexual Offender, Volume V. Kingston, NJ: Civic Research Institute, 2005.

Creeden, K., *Trauma and neurobiology: Considerations for the treatment of sexual behavior problems in children and adolescents*. In R. Longo & D. Prescott (Eds.) Current Perspectives: Working With Sexually Aggressive Youth and Youth With Sexual Behavior Problems. Holyoke, MA: NEARI Press, 2005.

Lew, M. Victims No Longer, Quill, 2004

National Task Force on Juvenile Sexual Offending (1993). The revised report from the National Task Force on Juvenile Sexual Offending of the National Adolescent Perpetrator Network. Juvenile & Family Court Journal, 44 (4), 1-120.

Prescott, David S., and Longo, Robert E., *Current Perspectives: Working with Young People Who Sexually Abuse*, Current Perspectives: Working with Sexually Aggressive Youth & Youth With Sexual Behavior Problems, Longo, Robert E and Prescott, David S., Editors, NEARI Press, 2006, page 53-54.

Prescott, David S., Risk Assessment of Youth Who have Sexually Abused - Theory, Controversy and Emerging Strategies, Wood & Barnes Publishing, 2006

© Copyright 1994 by Utah NOJOS

Rasmussen, L. A., Burton, J., & Christopherson, B. J. (1992). Precursors to offending and the Trauma Outcome Process in sexually reactive children: Journal of Child Sexual Abuse, 1(1), 33-48.

Rich, P., Understanding, Assessing, and Rehabilitating Juvenile Sexual Offenders, John Wiley & Sons, Ltd., 2003

Rich, P., Attachment and Sexual Offending: Understanding and Applying Attachment Theory to the Treatment of Juvenile Sexual Offenders, John Wiley & Sons, Ltd., 2006

Ryan, G. and Lane, S., Juvenile Sexual Offending Causes and Consequences. New and Revised Edition, Jossey-Bass A Wiley Company, 1997

Ward, T., Polaschek, D., and Beech, A., Theories of Sexual Offending, John Wiley & Sons, Ltd., 2006

Additional Reference Books and Articles

Allen, J. G. (2001). Traumatic Relationships and Serious Mental Disorders. New York, NY: Wiley & Sons.

Alexander, P.C. & Anderson, C. L. (1997). Incest, attachment and developmental psychopathology. In Cicchetti, D. & Toth, S. (Eds.) *Rochester Symposium on Developmental Psychopathology,* 8, 343-377. Rochester, NY: University of Rochester Press.

Araji, S.K. (1997). Sexually Aggressive Children: Coming to Understand Them. Thousand Oaks, CA: Sage Publications.

Balbernie, R. (2001). Circuits and circumstances: The neurobiological consequences of early relationship experiences and how they shape later behavior. *Journal of Child Psychotherapy*, 27 (3), 237-255.

Baranowsky, A., Gentry, J. E., & Schulta, D. R. (2005). Trauma Practice: Tools for Stabilization and Recovery. Cambridge, MA: Hogrefe and Huber.

Barbaree, H.E., Marshall, W. L. & Hudson, S.M. (1993). The Juvenile Sex Offender. New York, NY: The Guilford Press.

Bergman, J. & Hewish, S. (2003). Challenging Experience. Oklahoma City, OK: Wood and Barnes. (Includes psycho-drama exercises.)

Blair, R. & James, R. (2001). Neurocognitive models of aggression, the antisocial personality disorders and psychopathy. *Journal of Neurology, Neurosurgery and Psychiatry,* 71(6), 727-731.

Bonner, B. L. & Fahey, W. E. (1998). Children with aggressive sexual behavior. In N.N.

© Copyright 1994 by Utah NOJOS

Singh & A.S. W. Winton (Eds.) Comprehensive Clinical Psychology: Special Population (Vol. 9). Oxford, England: Elsevier Science.

Bowlby, J. (1973) Attachment and Loss. Volume II: Separation: Anxiety and Anger. New York: Basic Books.

Bremner, J. S. (2002). Does Stress Damage the Brain? New York: Norton.

Burk, L. & Burkhart, B. (2003). Disorganized attachment as a diathesis for sexual deviance: Developmental experience and the motivation for sexual offending. *Aggression and Violent Behavior,* 8(5), 487-511.

Burton, D. L. (2000). Were adolescent sexual offenders children with sexual behavior problems? *Sexual Abuse: A Journal of Research and Treatment,* 12 (1), 37-48.

Burton, D. L., Nesmith, A.A. & Baden, L. (1997). Clinician's views on sexually aggressive children and their families: A theoretical exploration. *Child Abuse and Neglect,* 21 (2), 157-170.

Caffaro & Conn-Caffaro. Sibling Abuse Trauma. Assessment and intervention strategies for children, families and adults.

Chaffin, M. Letourneau, E. & Silovsky, J. (2002). Adults, adolescents and children who sexually abuse children: A developmental perspective. In J.E.B. Myers, L. Berliner, J. Briere, C. Jenny, T. Hendrix & T. Reid (Eds.), The APSAC Handbook on Child Maltreatment (2nd Ed.). Thousand Oaks, CA: Sage Publications.

Connor, D., Doerfler, L., Volungis, A., Steingard, R., & Melloni, R. (2003). Aggressive behavior in abused children. *Annals of the New York Academy of Sciences,* 1008, 79-90.

Cook, A., Spinazzola, J. et al (2005). Complex trauma in children and adolescents. *Psychiatric Annals,* 35 (5), 390-398.

Creeden, K. (2004). Integrating trauma and attachment research into the treatment of sexually abusive youth. In M.C. Calder (Ed.), Children and Young People Who Sexually Abuse: New Theory, Research, and Practice Developments. Lyme Regis, Dorset: Russell House Publishing.

Creeden, K. (2005). Trauma, attachment and neurodevelopment: Implications for treating sexual behavior problems. In B. Schwartz (Ed.), The Sexual Offender, Volume V. Kingston, NJ: Civic Research Institute.

Creeden, K. (2005). Trauma and neurobiology: Considerations for the treatment of sexual behavior problems in children and adolescents. In R. Longo & D. Prescott (Eds.) Current Perspectives: Working With Sexually Aggressive Youth and Youth With Sexual Behavior Problems. Holyoke, MA: NEARI Press.

© Copyright 1994 by Utah NOJOS

Crittenden, P.M. (1997) Toward and integrative theory of trauma: A dynamic-maturation approach. In Cicchetti, D. & Toth, S. (Eds.), *Rochester Symposium on Developmental Psychopathology,* 8, 33-84. Rochester, NY: University of Rochester Press.

DeBellis, M.D. (2001). Developmental traumatology: The psychobiological development of maltreated children and its implications for research, treatment and policy. *Development and Psychopathology*, 13, 539-564.

Fago, D. P. (2003). Evaluation and treatment of neurodevelopmental deficits in sexually aggressive children and adolescents. *Professional Psychology: Research and Practice,* 34 (3), 248-257.

Friedrich. W. N. (2002). Psychological Assessment of Sexually Abused Children and Their Families. Thousand Oaks, CA: Sage Publications.

Gray, A. Pithers, W.D., Busconi, A., & Houchens, P. (1999). Developmental and etiological characteristics of children with sexual behavior problems: Treatment implications. *Child Abuse and Neglect,* 23 (6), 601-621.

Guggino, J. M. & Ponzetti, Jr. J. (1997) Gender differences in affective reactions to first coitus. *Journal of Adolescence*, 20 (2), 189-200.

Hall, D. K., Mathews, F. & Pierce, J. (2002). Sexual behavior problems in sexually abused children: A preliminary typology. *Child Abuse and Neglect,* 26, 289-312.

Jensen, E. (2000). Different Brains, Different Learners: How to Reach the Hard to Reach. San Diego, CA: The Brain Store.

Kinniburgh, K., Blausteink, M. & Spinazzola, J. (2005). Attachment, self-regulation and competency. *Psychiatric Annals*, 35 (5), 424-430.

Kornblum, R. (2002). Violence Prevention Through Movement and Pro-social Skills. Oklahoma City, OK: Woods and Barnes.

Maddock & Larson. Incestuous Families.

Marshall, W.L. & Marshall, L.E. (2000). The origins of sexual offending. *Trauma, Violence and Abuse: A Review Journal*, 1, 250-263.

Morgan, A. & Lilienfield, S. (2000). A meta-analytic review of the relation between antisocial behavior and neuropsychological measures of executive function. *Clinical Psychology Review*, 20, 113-136.

Ogden, P. & Minton, K. (2000). Sensorimotor psychotherapy: One method for processing traumatic memory. *Traumatology*, 6 (3).

© Copyright 1994 by Utah NOJOS

Perry, B. (2001) The neurodevelopmental impact of violence in childhood. In Schetky, D. & Benedek, E. (Eds.) Textbook of Child and Adolescent Forensic Psychiatry. Washington, D. C.: American Psychiatric Press.

Prentky, R., Harris B., Frizzell, K., & Righthand, S. (2000). An actuarial procedure for assessing risk with juvenile sex offenders. *Sexual Abuse: A Journal of Research and Treatment,* 12 (2).

Rasmussen, L. A. (1999). Factors related to recidivism among juvenile sexual offenders. *Sexual Abuse: A Journal of Research and Treatment,* 11, 69-85.

Righthand, S. & Welch, C. (2001). Juveniles Who Have Sexually Offended: A Review of the Professional Literature. Washington, DC: Office of Juvenile Justice and Delinquency Prevention.

Schore, A. N. (2001). Effects of a secure attachment relationship on right brain development, affect regulation and infant mental health. *Infant Mental Health Journal*, 22 (1-2), 7-66.

Silovsky, J.F. & Niec, L. (2002). Characteristics of Young children with sexual behavior problems: A pilot study. *Child Maltreatment,* 7, 187-197.

Stein, P. & Kendall, J. (2004). Psychological Trauma and the Developing Brain. New York, NY: Haworth Press.

Teichner, G. & Golden, C. (2000). The relationship of neuropsychological impairment to conduct disorder in adolescence: A conceptual review. *Aggression and Violent Behavior*, 5, 509-528.

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ATSA List Serve Suggested Resources

PSYCHOSEXUAL EDUCATION RESOURCES

Allred, Terri, MTS, & Burns, Gary, MS. (1997). STOP just for kids: for kids with sexual touching problems by kids with sexual touching problems. The Safe Society Press: Brandon, Vermont.

Burton, Jan Ellen, PhD, Rasmussen, Lucinda, A., PhD, Bradshaw, Julie, LCSW, Christopherson, LCSW, & Huke, Steven C., MS. Treating children with sexually abusive behavior problems: guidelines for child and parent intervention.

Cunningham, Carolyn & MacFarlane, Kee. (1996). When children abuse: group treatment strategies for children with impulse control problems. The Safer Society Press: Brandon, Vermont.

Harris, Robie H. (1994). It's perfectly normal: Changing bodies, growing up, sex and sexual health. Candlewick Press: Cambridge, Massachusetts.

Hindman, Jan. (1985). The very touching book: For little people and for big people. AlexAndria Associates: Ontario, Oregon.

Johnson, Toni Cavanagh, PhD. (1998). Sexuality curriculum for abused children and young adolescents, and their parents (revised and expanded from child sexuality curriculum for abused children and their parents). Toni Cavanagh Johnson, PhD.

Johnson, Toni Cavanagh, PhD. (1998). Treatment exercises for child abuse victims and children with sexual behavior problems. Toni Cavanagh Johnson, PhD: South Pasadena, California.

Karp, Cheryl L., Butler, Traci L., & Bergstrom, Sage C. (1998). Activity manual for adolescents. Sage Publications: Thousand Oaks, California.

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TARGETED SEX-SPECIFIC THERAPY RESOURCES

WORKBOOKS

Delson, Niki. Using Conscience as a Guide: Exploring Sex Offender Treatment in the Moral Domain. www.neari.com/catalogue 03.html.

(This includes a manual and a student workbook. The anchor domain of conscience functioning is Attachment, and several questions explore early-childhood memories of important relationships and their contributions to the creation of a moral core. These books are based on the research of Barbara Stillwell, M.D. and Matthew Galvin, Ph.D. and their work with traumatized youth.)

Kahn, Timothy J. (2001). Pathways: A guided workbook for youth beginning treatment, 3rd Ed. Safer Society Press.

Kahn, Timothy J. (2002). Pathways: Guide for Parents of youth beginning treatment, 3rd Ed. Safer Society Press.

Kahn, Timothy J. Footprints: A guided workbook for youth with low levels of intellectual functioning. Safer Society Press.

Kahn, Timothy J. (1999). Road Map to Recovery. Safer Society Press.

Schladale, J. (2002). Trauma Outcome Process (T.O.P.) Workbook: Resources for Resolving Violence. Freeport, LME.

Steen, Charlene. (1999). The Relapse Prevention Workbook for Youth in Treatment. Safer Society Press.

Westheimer, Ruth. (2000). Sex for Dummies, 2nd Ed. For Dummies.

(Accurate information related to sex education: puberty/maturation, reproduction, foreplay, intercourse, STD's, birth control, relationships, changes in sexuality as people age, how to talk to kids about sex, etc.)

Streetwise to Sexwise. The Center for Family Life Education. Planned Parenthood.

BOOKS FOR ADOLESCENTS ON HUMAN SEXUALITY

Brown, L., & Brown, M. (2000). What's the Big Secret?: Talking about Sex with Girls and Boys, Reprint Ed. Little, Brown Young Readers.

Cole, Joanna. (1988). Asking About Sex and Growing Up. William Morrow & Co., Inc.

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Gordon, S. & Cohen, V. (1992). Facts About Sex for Today's Youth, updated edition. Prometheus Books.

Gordon.S. (2001). How Can You Tell If You're Really In Love? Adams Media Corporation.

Gordon.S. (1990). Why Sex is Not Enough, Revised Ed. Adams Media Corporation.

Gordon, S. & Gordon, J. When Loving Hurts.

Girls Are Girls and Boys Are Boys, So What's the Difference?

Gordon, S., Gordon, J., & Cohen, V. (1992). A Better Safe Than Sorry Book: A Family Guide for Sexual Assault Prevention. Prometheus Books.

Harris, R.H. (2000). It's So Amazing! A Book about Eggs, Sperm, Birth, Babies, and Families. The Horn Book Magazine.

Harris, R. H., & Emberley, M. (2004). It's Perfectly Normal: Changing Bodies, Sex and Sexual Health, 10th Anniversary Ed. Candlewick Press.

Joannides, P. (2001). Guide to Getting It On, New Ed. Vermillion. www.goofyfootpress.com.main.

Madaras, L. (2000). My Body, My Self For Girls. New York: New Market Press.

Madaras, L. (2000). My Body, My Self For Boys. New York: New Market Press.

Madaras, L. (2000) My Feelings, My Self. News York: New Market Press.

Peter, V. & Dowd, T. (2000). Boundaries: A Guide For Teens. Boys Town, Nebraska: Boys Town Press.

BOOKS FOR YOUTH ON SEXUALITY (8 – 12 years old)

Madaras, L. (1993). The "What's Happening To My Body?" Book for Girls. New York: Newmarket Press.

Madaras, L. (1993) The "What's Happening To My Body?" Book for Boys. New York: Newmarket Press.

BOOKS FOR YOUTH ON SEXUALITY (3 – 8 years old)

Brown, L. K. & Brown, M. (1997). What's the Big Secret? Talking About Sex With Girls and Boys. New York: Little Brown.

Cole, J. (1993) How Were You Born? New Jersey: Wilmore, Inc.

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Gordon, S. & Gordon, J. (1990) Did the Sun Shine Before You Were Born? New York: Prometheus Books.

Meredith, S. (1991). Where Do Babies Come From? Usborne, OK: Starting Point Science.

Nelson, L. (1993) How Was I Born? New York: Dell Trade.

Schoen, M. (1990) Belly Buttons Are Navels. New York: Prometheus Books.

BOOKS FOR PARENTS ON SEXUALITY

Gordon, S. & Gordon, J. (1999). Raising a Child Responsibly in a Sexually Permissive World, 2nd Ed. Adams Media Corporation.

WEBSITES

Perry, Bruce. www.childtraumaacademy.com/surviving_childhood/index.html.
Free on-line courses offered by the Child Trauma Academy on topics such as “Bonding and Attachment in Maltreated Children” and “Surviving Childhood: An Introduction to the Impact of Trauma”. CEU’s available for practitioners in Texas and California.

www.childtrauma.org/ctamaterials/Professions/asp
Childhood trauma topics.

www.neari.com
Various publications.

www.kids-in-mind.com/
Film reviews regarding sexual content, violence, language, etc.

www.healthteacher.com/
Sexuality for youth.

www.guttmacher.org/pubs/fb_sex_ed02.pdf National Council on Juvenile and Family Court Judges. (Note: an underline “_” appears before an after “sex”.)

www.guttmacher.org/pubs/fb_teens.pdf National Council on Juvenile and Family Court Judges. (Note: an underline “_” appears before “teens”.)

www.socio.com/srch/summary/pasha/paspp03.htm
Search Institute

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www.tlcinst.org
National Trauma and Loss Institute

http://www.darkness2light.org
From Darkness To Light: Darkness to Light is a non-profit organization dedicated to the primary prevention of child sexual abuse.

DVD/VIDEO

General Themes

"Offenders and Survivors Speak Out On Sexual Abuse" DVD, www.speakoutvideo.com.

"Why God, Why Me?"
Video focused on victim empathy.

" Drug Called Pornography"
Video about pornography and how it can be addicting.

"Things Behind the Sun"
Video depicts an adult who was raped as a teenager and who abuses alcohol and engages in risky sexual behavior as an adult.

"He Got Game" Rated R
"The Good Son" Rated R

"Imaginary Heroes" Rated R

"End of the Spear" Rated PG-13

"Hotel Rwanda"
Domestic strife, survival, war. Rated PG-13

"Coach Carter"
Therapeutic theme, cultural values, family issues, etc. Rated PG-13

Family Abuse Themes
"Nuts" Rated R
Incest dynamics, victim impact

"Bastard Out of Carolina"
Video depicts the sexual abuse of a young girl by a stepfather, various family members' reactions, and the effects on the family. (It was recommended that a juvenile have at least 9 months of therapy before viewing this film because of the level of sexual arousal to children elicited by this film.)

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“Antwone Fisher”
Video involving abuse. Rated PG-13

“Domestic Disturbance” Rated PG-13
Video involving violence, brief sexuality, language.

“Good Will Hunting”

“Once Were Warriors” Rated R.
Pervasive language and strong depiction of domestic abuse, including sexual violence and substance abuse.

“Rabbit Proof Fence” Rated PG
Emotional thematic material.

Family Themes

“Ahkjeelah and the Bee” Rated PG
Video depicts family struggles, single parent.

“Dead Poets Society” Rated PG

“House of D” Rated PG-13

“Fathers and Sons” Rated R

“Whale Rider” Rated PG-13

“Radio” Rated PG

“I Am Sam” Rated PG-13

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